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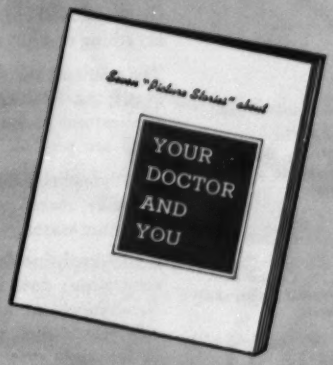

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1. Parsons, L., and Tenney, B., Jr.: M. Clin. North America *34*:1537, 1950.
2. Greenblatt, R. B.: J. Clin. Endocrinol. & Metab. *13*:828, 1953.

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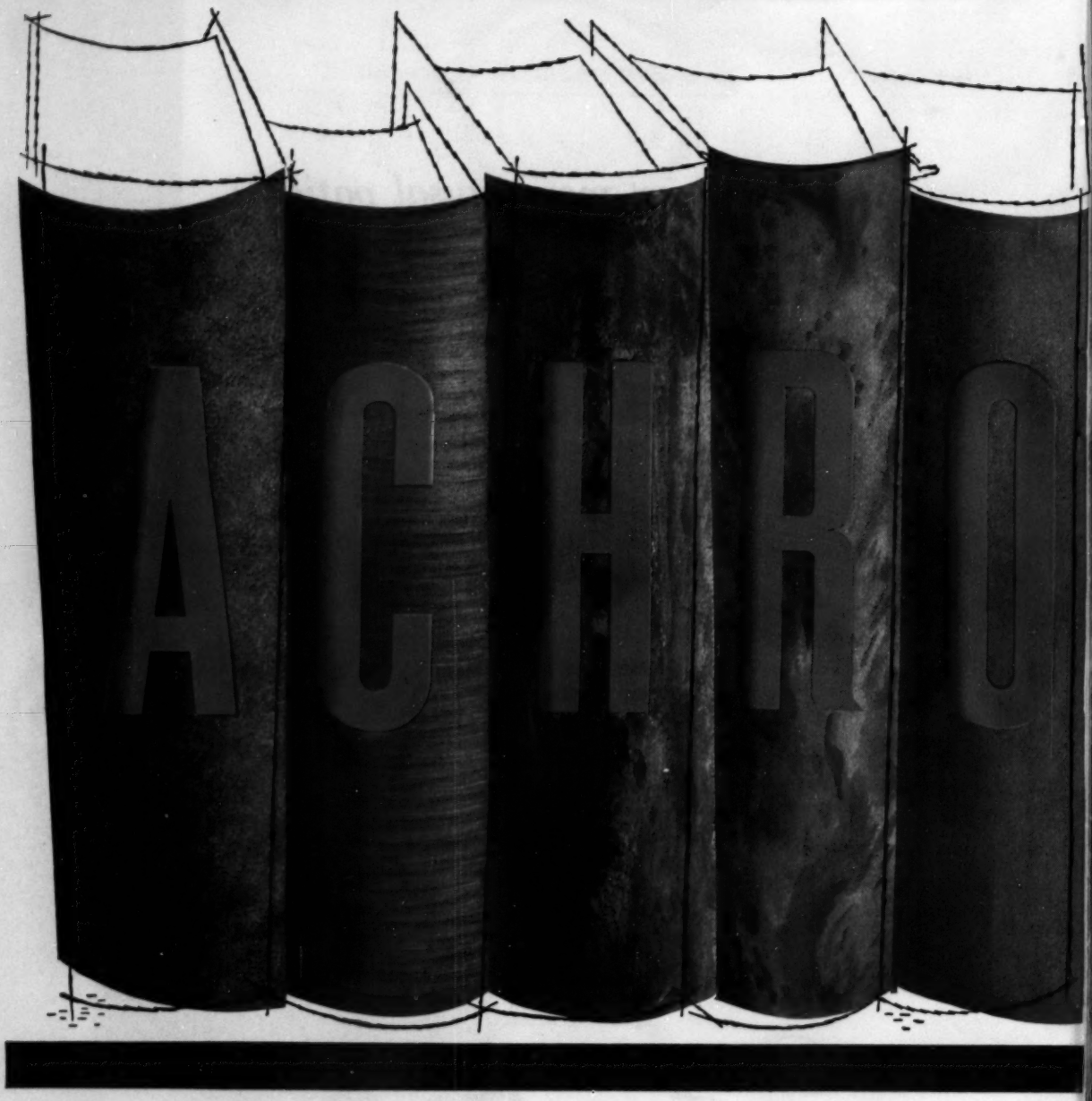

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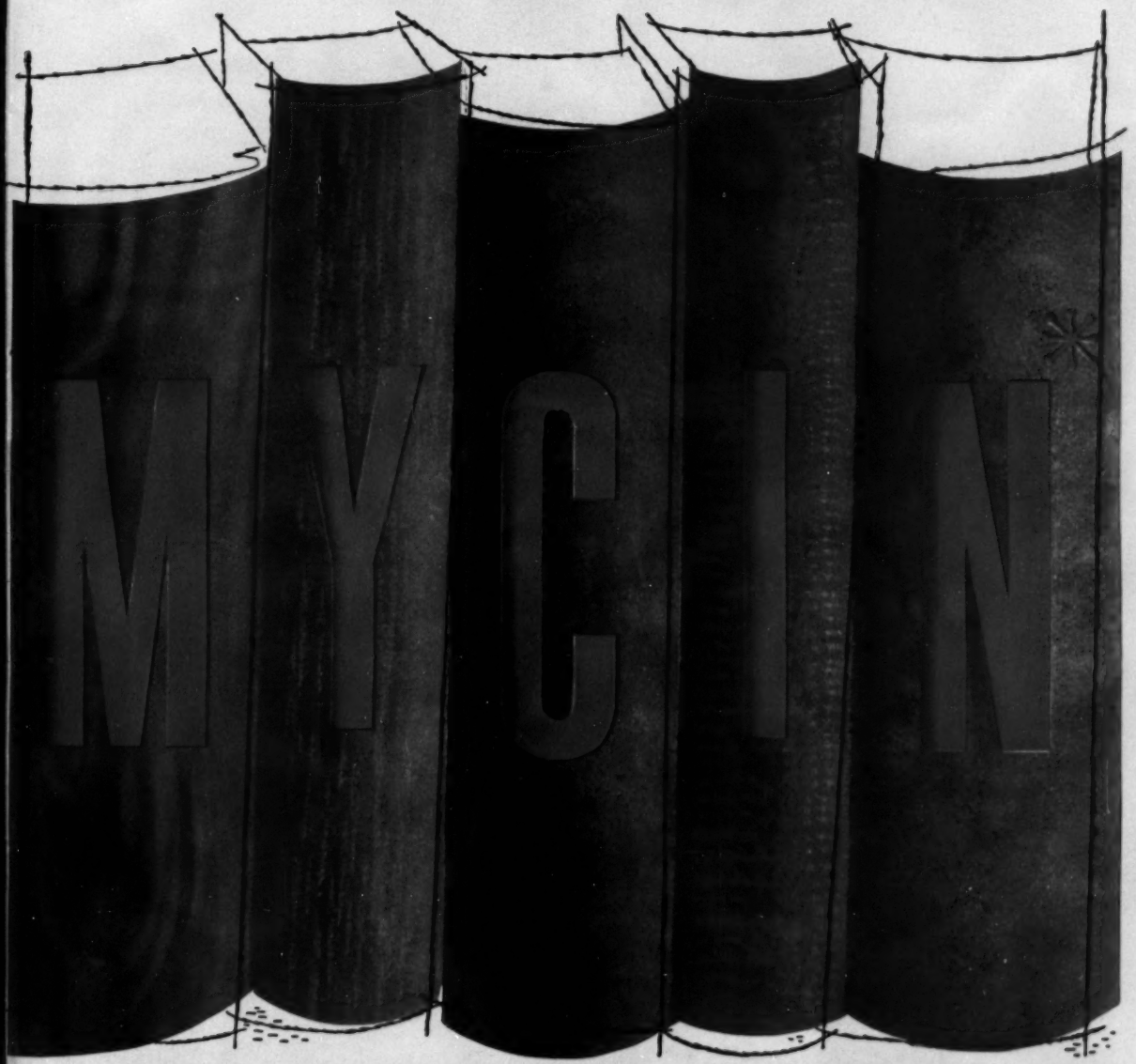

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DELAWARE STATE MEDICAL JOURNAL

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MENTAL HEALTH TRAINING AND RESEARCH IN THE SOUTHERN REGION

M. A. TARUMIANZ, M. D.,*
Farnhurst, Del.

Although significant progress has been achieved in recent years in the methods of treatment of mental diseases and in the provision of facilities for the care of patients with mental disorders and incapacitating neuroses, the problem is staggering in terms of the toll in human and material resources. Studies[1] have shown that almost 50% of the hospital beds in the United States are for mentally ill patients. In 1951 the daily census of patient load in mental hospitals was 697,521, and during that year more than 900,000 patients with mental disorders were treated. One aspect of the problem is the increase in the number of persons 60 years and older who are being admitted to state mental hospitals. Since 1939 the number of "elder citizens" has increased 25%, but the number of patients of this age group now in mental hospitals has increased 58%. Of all the first admissions in state mental hospitals approximately 34% are persons in the older age bracket. In 1952 over one billion dollars of public funds were expended in the care and treatment of the mentally ill, $2,900,000 per day.

The mental health problem of the country is even more grave when the short supply of trained psychiatric personnel is considered. The enormous need for psychiatrists is probably the most critical handicap faced by persons and agencies interested in improving the national mental health program. The American Psychiatric Association standard for the staffing of mental hospitals is one physician for each 30 patients in intensive treatment, and one for each 150 patients in continued treatment. Using this standard, the state of Texas estimated that 230 psychiatrists are needed immediately to staff its state hospital system. At present 40 psychiatrists are employed in the Texas state hospital system.[2] The need for clinical psychologists, psychiatric social workers, and psychiatric nurses is not much less than that for psychiatrists.

The Texas need is duplicated proportionately in state after state. Even in Delaware, with its population of about 350,000, the mental health institutions are considerably understaffed. Statistics such as these have pointed up two incontravertible facts, viz. (1) that there must be increased and intensive research to discover new ways of preventing mental disorders and of treating and rehabilitating mentally ill patients; (2) that a greatly increased program of training psychiatric personnel must be developed to make use of the techniques for prevention and treatment which research brings forth.

The problem of the increase in mental patients and the lack of trained personnel to treat them has been reflected in requests to state legislatures for increased appropriations for construction of facilities to relieve the overcrowding and for higher salaries as one means of attracting and maintaining well-qualified professional personnel. The Governors of the 16 southern states, Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, meeting in conference at Hot Springs, Virginia, in

*Superintendent of Delaware State Hospital and Governor Bacon Health Center; Chairman, Governor's Committee on Mental Health Training and Research in Delaware.

1Endicott, K. M., and Allen, E. M.: "The Growth of Medical Research, 1941-53 and the Role of Public Health Service Grants," Science, 118: 337-343, 1953.

2Texas Reports on Mental Health Training and Research, 1954.

November, 1953, had this matter as a major item on their agenda. On November 4, 1953, these governors passed a resolution asking the Southern Regional Education Board to conduct an immediate survey of the facilities and personnel in the southern states for the training of psychiatric personnel and for research; that the individual states make official surveys of their training and research resources, considering especially their needs in personnel and facilities to raise the mental institutions in each state to the level of residency or affiliate accreditation; and that the results of the state surveys be presented to the 1954 regional mental health conference, and that the Southern Regional Education Board report to the 1954 Southern Governors' Conference the results of its action and any action taken.

The Southern Regional Education Board obtained a grant of $51,300 from the National Institute of Mental Health to finance the project in part.[3] An additional $2,000 was provided to help finance the survey of state resources for training and research in mental health. Dr. Nicholas Hobbs, Chairman of the Division of Human Development and Guidance, George Peabody College for Teachers, Nashville, Tennessee, was appointed director of the project, and the project office has been established at the Joint University Libraries, Nashville, Tennessee. The Commission on Mental Health Training and Research, comprising a group of distinguished professional and governmental persons, was organized and held its first meeting on January 15-16, 1954 at which time the Honorable Frank Clement, Governor of Tennessee, was elected chairman. A meeting was then held on February 1-2, 1954, in Nashville, Tennessee, of about 60 mental health officials and university representatives who had been appointed by their Governors. At this meeting procedures to be used in the project were defined.

The objective of the project as stated by the Commission on Mental Health and Research is "to strengthen programs of mental health through increasing the number and quality of personnel and the scope and quality of research which contribute to the solution of mental health problems." The project is concentrated principally on training and research in psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing, and will survey research in behavioral and biological sciences related to mental health. Statements will also be prepared on problems of training and research in occupations and professions related to mental health such as medicine, the clergy, teaching, school administration, law.

His Excellency, J. Caleb Boggs, Governor of Delaware, appointed M. A. Tarumianz, M. D. Chairman of the committee for this state and named to this committee 66 other persons representing a variety of institutions, agencies and groups in the state concerned with mental health. At its first meeting on May 18, 1954, the Governor's Committee appointed a Working Committee of 20 under the chairmanship of M. A. Tarumianz, M. D.

The project staff had prepared schedules for use in surveying the resources for training and research in mental health in the various states. The Delaware Committee circulated schedules of the following types to 19 persons:

(a) Schedule for Mental Health Institutions and Agencies 8
(b) Schedule for University Department doing Basic Research in Mental Health—Part 1—Schedule for Dean of Graduate School 1
(c) Part II—Schedule for University Departments concerned with Research on Mental Illness or Mental Health 3
(d) Schedule for Departments of Psychology 1
(e) Schedule for Individual Investigators 6

The response to the questionnaires was 100%.

The survey showed the following personnel available in mental health institutions:

19 Psychiatrists—(15 full time and 4

[3] *State Government*, April, 1954, published by the Council of State Governments, Chicago, Illinois.

part time), of whom 9 are Diplomates of the American Board of Neurology and Psychiatry, and 6 are eligible for membership.

9 Clinical Psychologists—(8 full time, 1 on leave for study), of whom 2 are Diplomates of the American Board of Examiners of the American Psychological Association, and 1 eligible for membership.

8 Professors of Psychology—(7 full time and 1 part time), all of whom have the Ph.D. degree, 1 being a Diplomate of the American Psychological Association.

3 Professors of Sociology—2 with the Ph.D. degree, 1 with the M. A. degree.

12 Psychiatric Social Workers—(10 full time, 2 part time), of whom 5 are members of the American Association of Psychiatric Social Workers.

52 Psychiatric Nurses—(49 full time, 3 part time), of whom 2 have the M. S. degree, 2 the B. S. in Nursing Education degree.

In order to strengthen and extend a program of training and research in mental health in Delaware the following personnel are needed:

10 Psychiatrists, including 1 Child Psychiatrist

4 Clinical Psychologists

10 Psychologists

1 Psychometrist

2 Assistant Professors of general, experimental, and clinical psychology,

10 Psychiatric Social Workers

19 Psychiatric Nurses, including 1 nurse education coordinator and 4 instructors.

The addition of the needed staff would make possible the training of the following number of students in Delaware: (a) 11 residents in psychiatry; (b) 9 clinical psychology interns; (c) 9 psychiatric social work students; (d) 84 psychiatric nursing students; (e) at the University of Delaware, 6 additional students for Master's degrees, 6 for the Doctorate, (all areas), 3 for the Doctorate in clinical psychology only.

The survey of the resources for research related to mental health revealed a full-time coordinator of research employed by one institution, 16 research projects in progress; one institution has 3, one has 5, one has 7, and one individual investigator has 1. This research has been supported by the regular budgets of the Delaware State Hospital and Governor Bacon Health Center, drugs contributed by Eli Lilly Co., the U. S. Army Medical Service—Office of the Surgeon General, Radio Corporation of America—R. C. A. Victor, University of Delaware Faculty Committee on Research, the budget of the University of Delaware Department of Psychology, the U. S. Navy formerly—now personal funds of an individual investigator. Participants in the survey indicated lack of funds, time, and personnel as major tangible obstacles to research, while the "climate" for research in the institutions studied is generally favorable.

The representatives of the state committee met with the central staff of the Project in Atlanta, Georgia, on June 23, 1954, and on June 24 with the Commission on Mental Health Training and Research. All of the participating states but Arkansas and South Carolina were represented and presented summaries of the major resources and needs in mental health training and research as shown by the survey made in each state. These reports indicated that these 16 states are seriously lacking in personnel to staff their institutions for training according to the standards of the evaluation agencies such as the American Psychiatric Association and the American Psychological Association, etc., that no state had specifically designated funds for research purposes in mental health, and that those states reporting considerable research in this area in progress or recently completed were those with several medical schools, and/or universities offering the Ph.D. degree in education, psychology, sociology, and related fields, and that several of the southern states have no institutions for the training of social workers or for

training of psychiatric nurses on the graduate level. All of these states indicated the need for funds to employ additional personnel, to pay higher salaries and stipends in order to recruit and maintain in the states well-qualified training personnel and students, to release personnel from teaching and service responsibilities in order to give time for research, and to employ research directors and other full-time research personnel.

In the meeting with the Commission on Mental Health Training and Research on June 24th the state representatives received the proposal that the 16 states of the Southern Governors' Conference establish and support a Mental Health Council for the Southern Region. This proposal was the outgrowth of recommendations of three special technical panels which had been held in April in Atlanta, Georgia, and recommendations from several states. This Regional Council would be a central research institute which would stimulate and strengthen state programs of research and the training of personnel by the following means:

(1) Granting research funds to institutions, universities, agencies, and individuals.

(2) Awarding training grants, (scholarships, travel grants, fellowships), to institutions and individuals to develop already existing scientific talent and new talent.

(3) Providing expert consultation to states for the development of special research facilities which are planning educational programs and other means of improving and expanding research activities.

(4) Assisting in communication between research scientists on problems of mental health research.

(5) Helping to suport the interpretation of research problems and results.

(6) Seeking more effective ways of using available personnel and the special resources for research offered by the states.

(7) Helping existing centers for training research personnel to expand and improve their efforts.

This Council will be concerned exclusively with research in the biological and behavioral sciences. The Southern Regional Education Board was asked to study the alternative methods suggested for organizing the Council, viz.: (1) to have the Council attached to the Southern Regional Education Board, (2) to have a new autonomous organization under a mental health compact approved by the legislatures of the states involved. A method of financing a regional Council of Mental Health was included in the proposal. The state representatives accepted the proposal with the omission of the section regarding financing the Council. The latter action was based on the conviction that further study concerning ways of financing the Council was needed.

On July 15, 1954 the Working Committee of the Governor's Committee on Mental Health Training and Research met at Farnhurst, and approved fourteen recommendations which will be presented to the Regional Conference on Mental Health Training and Research in Atlanta, Georgia, on July 21-24, 1954. Some of the recommendations will strengthen the mental health program in Delaware. Several are concerned with ways by which Delaware can contribute to improving such a program in the sixteen southern states. Still others point up ways by which other states of the Southern Region can assist Delaware in training psychiatric personnel and conducting research to prevent and treat mental disorders.

Included in the recommendations is a request to the Legislature "to appropriate $214,000.00 to establish a coordinated program of research and training throughout the state, by improving the personnel and facilities for research and training at the five Delaware institutions—Delaware Colony, Delaware State Hospital, Governor Bacon Health Center, Welfare Home, and the University of Delaware."

Another of the recommendations, one which should be of particular interest to

the physicians of Delaware and the other southern states, is the following: "That in order to stimulate greater interest in research and mental health, the states seek to establish closer relationships between mental health specialists and general medical personnel through enlarging neuropsychiatric units in general hospitals and establishing mental hygiene clinics and outpatient centers in areas not now served."

Inasmuch as the southern states, like most of the other states in the country, are seriously lacking in psychiatrists, a recommendation was made that "The Southern Region investigate methods by which refugee professional personnel may have the opportunity of accepting rotating interneship programs and thus may qualify for the State Board examinations in those states," and that legislatures of states willing to employ "well-qualified foreign physicians, psychiatrists, and other psychiatric personnel, be asked to make the necessary arrangements for licensing such persons to practice in their states."

Delaware is the only southern state with a residential treatment center for maladjusted children. (North Carolina's new psychiatric hospital to be opened in the fall of 1954 will include an in-patient children's service). The Working Committee recommended that "arrangements be effected with other states by which the Governor Bacon Health Center may assist other states in residential treatment of maladjusted children," and "that Delaware coordinate with other states engaged in similar treatment, its research in the study of cerebral palsy and other spastic diseases of children."

The Working Committee expressed the opinion "that the Legislature should authorize the Governor to establish a special board composed of men and women from the Governor's Committee to assume the responsibility of approving research projects and allocating funds."

The training of psychiatric personnel and research in mental health in Delaware should benefit considerably by participation of the state in this Project of the 16 southern states. At the same time the region can benefit by a regional plan which will make available to other states some of the specialized facilities in Delaware for the care and treatment of persons with mental disorders and opportunities in the State for research.

PSYCHIATRIC RESEARCH

Realization or Missed Opportunity?

FRITZ A. FREYHAN, M. D.,*
Farnhurst, Del.

Our research intentions are good. There is growing awareness of the need for its expansion and intensification. Public support is sought and enlisted. Still more promising, appeals are made to arouse our professional conscience. In a recent report, for example, by the Group for the Advancement of Psychiatry concerned with research, the very comprehensive analysis of existing conditions begins as follows: "In few medical specialties is research more acutely needed than in psychiatry; and perhaps no comparably important area shows greater neglect."

One aspect of this crucial situation concerns the question whether we do or do not have an intellectual climate favorable to research. Highly sceptical opinions have been expressed by a growing number of critics who are undoubtedly motivated by a deep interest in mental health. The following quotation from a reply on the question of tangible or intangible barriers to research, coming from Dr. H. W. Elley, Chairman of the National Mental Health Association, defines the issues quite lucidly:

"There is a great deal to be said about paucity of research in our field. While, on the one hand, there is great need for research and there are important leads which should be pursued, the research proposals that are being offered today are too often not of high caliber. Research grants are bing made to projects of lower than top priority. In some places research funds are not being spent because of the lack of good projects . . . Professional

*Clinical Director, Delaware State Hospital.

training in our field . . . should help the trainee to know whether the techniques that he is using are scientifically well validated, are theories or schools of thought, or are simple guesses . . . Too often, instead he is taught a theory as if it were a well established fact and the trainee is indoctrinated with a school of psychiatry or human behavior as something to adhere to and be loyal to instead of being given a full range of theory and encouragement to form his own judgements and make his own choices." . . . "A critical study of the common serious mental health problems, that is, those of high priority, will reveal the unknowns which if solved by research could facilitate the handling of the problems, but clinical work is only rarely approached and recorded so as to reveal our areas of ignorance."

It would be foolish of us to deny that we have indeed a dilemma of preparedness which has come into existence quite independently of material and administrative handicaps that have blocked research expansion. In his recent presidential address in St. Louis, Dr. Kenneth Appel surveyed some of the limitations in the development of psychiatry as a science. He criticized the name-calling and dogmatism which disturb young psychiatrists and the public. He had this to say regarding a change:

"Partial remedies for this situation are: more objectivity in our studies and training; more historicity; more scientific methods and evaluation; more extension of the ideas of a university education in training a psychiatrist. Much of our training is assertion, conviction, indoctrination, rather than education. Restriction of interest, curiosity, and spontaneity are constricting, devitalizing, and castrating."

It is quite apparent, then, that we are not prepared to advocate research undertakings on a vast scale unless we succeed in clarifying some of the issues in this current dilemma. I believe that the prevailing substitution of faith and conviction for knowledge constitutes the greatest peril to a scientific climate. This state of affairs may well be perpetuated for as long as we remain indifferent to the dangers of defective cross professional communication. Is it not a rather ironical development that this has come about at the very moment at which we emphasize so strongly the all-importance of interpersonal communication in psychiatric therapy? We cannot deny that orientational conformity and group isolation have become characteristic for not a few training schools, institutes, and societies. You "belong" here or there and you share collective sympathies and hostilities. We will only be ready for coordinated attacks on mental health problems when we restore mutual respect for work in progress. Defensive dogmatism has resulted from operational isolation. Such conditions are hardly conducive to coordinated investigative productivity. Dr. Sargant of London, England, described a highly promising policy of psychiatric hospitals in England which consists of a deliberate effort to appoint psychiatrists from different school of thought, with contrasting theoretical and clinical backgrounds, to one and the same staff. The intention is to give the patients the advantage of every type of therapy, according to their individual needs, and at the same time bring about an intimate association of specialists. We, on the other hand, are frequently still fiercely separated by ideological loyalties.

Another development unfavorable to research is the growing unpopularity of public psychiatric hospitals among research-minded psychiatrists. There are, of course, many legitimate reasons contributing to this situation which have to do with a variety of administrative and clinical deficiencies, but there are other reasons involved which seem significant. It has not sufficiently been stressed, I believe, that many areas of clinical research can only be explored in these hospitals because of the non-selectivity of population samples, so imperative to testing and validation of empirical concepts. We have been slow in calling attention to this very important fact and have thus

failed to create a positive motivation in young psychiatrists for seeking appointments in state hospitals. In contrast to public hospitals which must admit every case sent there, patients in non-public hospitals are often highly selected on the basis of personality background, prognosis and suitability for specific therapies. It is one thing to compare clinical statistics of fracture or tumor patients without particular emphasis on hospital background. But it is quite meaningless to evaluate groups of patients, treated in hospitals of a different make-up, who have nothing else in common but a diagnosis of schizophrenia. While this is still being done every day, it is based on naive biological concepts according to which a disease is a disease regardless of the person in whom it develops. The philosophy of sampling is still relatively new in psychiatry. Generalizations of restricted clinical experiences are practiced in all camps and account for many contradictions, especially concerning therapeutic achievements.

The tremendous size of clinical material in hospitals and clinics, its variety and representativeness of innumerable variables, has hardly been recognized and recommended as the gigantic r e s e a r c h potential which it constitutes. We cannot overlook the fact that the strong turn of interest from the impersonal atmosphere of old-fashioned hospitals to the intimate privacy of the office has been a revolutionary development which has restored the respect for the uniqueness of the patient's individuality. It would be erroneous, however, to create a contrast between the individual-centered orientation of the therapist and the collectivistic view-point of the researcher. Many psychiatrists declare today that they are only interested in the type of research which stems from individual-centered therapy. We need not point out that such an attitude has serious methodological disadvantages. The aversion, implicit in this attitude, to investigations of a generic type, to evaluations and surveys on a collective scale, can perhaps be avoided if we realize the dual role in the function of the physician. In his role as therapist he is solely motivated by his intense desire to meet the individual needs of his patient. In his role as scientist, on the other hand, he must objectively evaluate his clinical experiences in order to discover facts and contribute to the modification of false concepts. To be able to do this he must be motivated by doubt. But doubt must not be equated with scepticism and then rejected because scepticism weakens therapeutic zest. By dispelling this confusion, by upholding and redefining our dualistic function, we may be successful in recruiting substantial numbers of talented physicians who have remained aloof thus far because of their devotion to therapy.

A final point to be taken up here concerns the problem of continuity in every type of psychiatric research which has to do with clinical outcome. This leads me to the unique opportunities in Delaware which have still not been truly recognized by those without whose organizational support research on a meaningful scale cannot materialize. It is one thing, and it is quite common today, to criticize and regret the lack of available information on epidemiology and outcome of mental disorders, but quite another matter to draw the consequences and facilitate appropriate investigations in a really adequate manner. We all know that we have no precise knowledge on such fundamental questions as the impact of preventive and therapeutic measures on personality disorders. The majority of clinical studies are based on short-term observations and leave us in doubt about subsequent developments. Educational and psychological designs for personality modification of maladjusted, neurotic and psychopathic personalities remain experimental and hypothetical due to the absence of continuous follow-ups. Case records, assembled day after day and year after year, contain a wealth of clinical and therapeutic experiences which represent a tremendous investment of highly qualified work. But this material the real value of which should be its availability for critical in-

tepretation and continuous follow-up dies a dusty death in file cabinets.

I have often pointed out the ideal human laboratory conditions in Delaware where the smallness of the state permits the concentration of every type of clinical material in one hospital and where continuous contact with all persons once treated creates no problem. Our recent studies on the outcome of schizophrenia concerned patients admitted since 1920. This pilot study should be expanded into an investigation of all schizophrenic patients in the state. The controlled conditions due to the concentration of all observations in one hospital and one mental hygiene clinic are highly favorable to a massive attack on certain problems of schizophrenia. Such investigations require a set-up which cannot be afforded without substantial help.

The singular continuity of studies as described must be regarded as a great advantage for research projects which aim to penetrate the still unknown relations between social influences and personality development, between personality and mental disorder and between therapies and social readjustment. Obviously, our opportunity for research achievement is unique. The decision for the long overdue exploitation must be made by those who have the means to provide their organizational support. It is then up to us to do the work.

ORGANIZATION

Of the Residential Treatment Center At Governor Bacon Health Center

JAMES A. FLAHERTY, M. D.,*
Delaware City, Del.

The residential treatment unit for maladjusted children at the Governor Bacon Health Center has been in existence since November, 1948. The children are under the care and treatment of trained psychiatrists, social workers, psychologists and residential workers. The Center has facilities for 175 children between the ages of 4 and 16 who require individual or group psychotherapy or residence in a therapeutic environment. There is also a service which is carried out in conjunction with the State Department of Public Welfare to afford shelter care for children from all three counties of the state.

The Center came into existence as a result of the efforts of Dr. M. A. Tarumianz. There were several areas of unmet need in the public health program of the state. Dr. Tarumianz, working through the Legislature and with the warm support of Bacon, then Governor, was able to secure the grounds and buildings of old Fort DuPont. The structures, their location and the recreational areas of the old Fort were readily adapted to the purposes for which they are now used.

FORM OF ORGANIZATION

The Governor Bacon Health Center, of which the residential treatment unit for children is a department, is closely affiliated with the Delaware State Hospital and operates under the authority of a board of trustees which also serves as the board for the State Hospital. The institution is administered by Dr. Tarumianz, who is Superintendent both of the Health Center and the Delaware State Hospital. The day-to-day program at the Center is under the supervision of a resident Medical Director, who serves also as Assistant Superintendent.

The Superintendent and the Board of Trustees hold monthly meetings at which time the activities at the institution are reviewed and executive, financial, and policy matters are discussed.

The Center operates on a state appropriation. Parents who can, contribute completely or in part to defray the expenses of the care and treatment of children who are patients at the Center.

BUILDINGS AND GROUNDS

The Health Center comprises 326 acres and it is bounded by the old canal on the north, by the Delaware River on the East, and the new Chesapeake and Delaware Canal on the south. Many of the buildings are permanent brick, fire-resistant structures. The children are housed in a series of cottages which were

*Medical Director and Assistant Superintendent, Governor Bacon Health Center.

formerly the homes of commissioned officers. These 14 cottages (two of which are reserved as dining rooms, kitchens, and apartments for personnel) are grouped together and are separated from the other services at the Center by a parade grounds which is centrally situated. Separate from the white cottages is Elbert Building, which is a large two-story frame structure in which Negro children are resident. There is a separate one-story frame cottage which houses the Negro girls. The Negro children have their own dining room facilities, in the Elbert Building.

The Administration Building is centrally located, and is adjoined by the Subadministration Building which houses the children's morning clinic, the offices for the Supervisor of Housecounsellors, Coordinator of Volunteer Services, the telephone exchange, and the social room which is reserved for the houseparents and staff meetings.

One section of the first floor of the large two-story hospital building is reserved for children who require bed care because of intercurrent illnesses.

In the Medical Center, which adjoins the hospital building, the x-ray Unit is housed. There are rooms for clinics. Here on a regular basis are held the nose and throat, ophthalmological, dermatological and endocrinological clinics. On the second floor there is a completely equipped operating room. Emergency surgery may be performed here and such elective surgery as certain orthopedic and nose and throat operations.

The children's cottages have beds for 10 children and are supervised by a housemother or housefather. The children's bedrooms and bathrooms are on the second floor of the cottages. The first floor is devoted to living rooms and playrooms and quarters for the houseparent. In several of the cottages the basements have been adapted as small workshops or clubrooms. When it is deemed necessary to remove a child from the group by reason of his disturbed and disturbing behavior, the child is isolated in a room in the hospital building. In the large Elbert Building there are two isolation rooms which may be used for this purpose.

Located between the Elbert section and the children's cottages is a brick theater with seating capacity for 330. Weekly motion pictures are shown here and entertainments are given by volunteer organizations. Here, too, are held the special assemblies of the children for general briefing on changes of program, rules, or other special matters which must be brought to the attention of the entire group. Adjoining the theater is a commissary, which is available to the children on scheduled hours, and a branch of the New Castle County Free Library which is open 6 days a week from 8:00 to 5:00 and which is freely used by the children.

Adjoining the library is Burton Hall, a large brick structure which serves as the center for indoor athletic activities. Here is located the offices of the Director of Recreation and his personnel. There is also a basketball court, mats for tumbling, bowling alleys, and rooms for ping pong and billiards. There is also a television set which can be used by groups at specially scheduled times. In the basement of Burton Hall is a well equipped home economics department where classes are held throughout the school day.

Adjacent to the Tilton Building is Hancker Building, which serves as the school building. The Education Department is staffed partly by the State Department of Education and by personnel from the Health Center. Because of the severity of the emotional problems of the children and because of their educational retardation or unreadiness, a regularly graded curriculum is not possible. The children are placed in groups according to their age and according to their capacity for learning and their ability to control their behavior. There is a kindergarten for the pre-school group, a shop in which woodwork and printing are taught and two special sections for children with severe reading disability and for a group who are of borderline intelligence.

The offices of the clinical team of psychiatrists, social workers, and psychologists are maintained in Booker Hall. This building serves as the center for treatment activities for the children. In this building evaluations for admissions are made and therapeutic interviews are conducted in the various offices. There are three playrooms and one larger room for group therapy. Staff meetings are held in this building in a staffroom on the second floor. Weekend passes for the children visiting their homes originate with the staff in this building and visitors to the children at the Center are screened here.

The immediate neighborhood of the Health Center is generally rural. Delaware City, which adjoins the Center, is a small town of 1,300 people. Many of the non-professional personnel at the Center are recruited from Delaware City and its environs. There is a public school immediately across the old canal from the Center. Children at the Center whose behavior and scholastic achievement justify it may attend the school. The relationship between the school authorities in Delaware City and the Center have been most cordial and cooperative.

Public transportation makes access to the Center reasonably convenient from the northern section of the state; however it is more difficult to reach the Center from the southern section of the state by bus.

INTAKE POLICY

Children are admitted to the Governor Bacon Health Center by direct referral from the State Mental Hygiene Clinics and indirectly from private and public agencies, courts, schools, and physicians. Children are evaluated by the staff prior to their admission to determine whether or not the admission of the child is advisable. This is decided after consideration of a number of factors, the principal among them being the treatability of the child, its age, and the existence of vacancies.

The following criteria determine eligibility of children for admission:

A. (1) Problems requiring study and diagnosis in a twenty-four hour living experience in an institution with a strong orientation towards mental health.
(2) Problems growing out of hostility and aggression which can not be contained in the home, school or wider community. We attempt to defer the admission of children with crystallized delinquency patterns. If the child has sufficient ego strength to warrant help and his, or her, behavior is such that it does not require maximum security, they are accepted on a provisional basis to test their ability to fit into our environment. However, not over five per cent of the population of the Center can be made up of children in this diagnostic category and the ages must be dispersed in the age range 7 to 13.
(3) Children who are withdrawn, overconforming, and dependent, and whose needs would be answered by a permissive, nondemanding environment.
(4) Children who have experienced tardiness in essential, basic habit training.
(5) Children with educational unreadiness or educational retardation growing out of emotional problems.
(6) Children whose family experiences are so damaging that foster home placement would be unsatisfactory and/or whose parents are so resistant to foster placement as to make it inadvisable.
(7) Pre-psychotic children and psychotic children are to be admitted providing they do not need maximum security.

B. Shelter care cases are accepted immediately at the request of the State Department of Public Welfare at anytime of day or night. A separate cottage with 18 beds is maintained for these children with a housemother continuously on duty. Shelter care children are maintained separately from the maladjusted children's group. They have their own dining facilities and receive whatever medical and nursing care is indicated. Should these children require additional psychiatric or psychological study, this is performed at the request of the Department of Welfare.

C. Children whose I. Q. is below 50 will not be admitted to the Center. It is our conviction that children with this degree of retardation can not profit from our program. Children with I. Q. of above 50 but below 70 receive special consideration by the staff to determine whether or not they could profit from residential care and could successfully adapt themselves to the population. Children with I. Q. of 70 and above are considered to be the group who would benefit most from residential care.

A large percentage of the children admitted to the Center have been under the care of community agencies for some time prior to their admission. An equally large percentage of the families of children admitted have been known to the courts, welfare or family agencies, or their mem-

bers have been under the care of Mental Hygiene Clinic or have been patients at the Delaware State Hospital. To the children admitted to the Center under the terms of our intake policy we undertake to offer individual or group psychotherapy to those who most require it. For those children for whom individual psychotherapy is not indicated we propose to offer a living experience which will promote normal growth and development and for those children who require it, an opportunity for special or remedial education.

STAFF

The children's treatment unit has 10 professional staff members who work directly with the children. There are 4 psychiatrists, one of whom serves part-time; 4 are social workers, one of whom serves on a part-time basis in a non-resident capacity and works with the parents of children from Kent and Sussex Counties. There are 2 psychologists who work all but a small fraction of their time with the children in the treatment unit.

Psychiatrists. The director of the treatment unit is a qualified child psychiatrist who supervises the treatment program and assigns cases to the various therapists. She likewise moderates the diagnostic and progress staff meetings. Another child psychiatrist, who is non-resident, visits the Center twice a week and carries a number of children in treatment and works with staff in a consultative capacity. The two other psychiatrists serve in the capacity of medical director and clinical director. Although both have worked with children, they have not completed their requirements in child psychiatry and are supervised by the director of the service.

Psychiatric Caseworkers. The chief psychiatric social worker supervises her casework staff and confers with the director of the treatment program on clinical and policy matters. She shares with her staff the preliminary screening of prospective admissions during evaluation visits. Each member of the social service staff is assigned a list of children for casework and some are carried in treatment under the supervision of the director of treatment. The members of the staff likewise carry a schedule of regular weekly casework interviews with parents of the children. The part-time caseworker for Kent and Sussex Counties maintains regular contacts with the parents of the children at the Center in the lower section of the state and assists in the staffing and the planning for the children's visits at home and/or discharge.

Houseparents. The Supervisor of Houseparents employs, orients and supervises the cottage parents. She has a full-time assistant who alternates with her when she is off duty. The Assistant takes the same responsibilities as the Supervisor when she is on duty.

The houseparents are a group of men and women ranging in age from 30 to 60 years of age, more than half of whom have completed high school and many of whom have had experience in some type of institutional setting which cared for children or adolescents.

The houseparent is responsible for maintaining the cottage as much along the lines of a genuine home as the demands of institutional living permit. They see that the children are properly clothed and bathed and that they get to their activities on time. They also participate in some aspects of the recreational program such as attending the theater with groups of children, going on fishing trips, etc. The houseparents are directly responsible to the Supervisor of Houseparents.

A regular in-service training program for the houseparents is conducted. Round table discussions moderated by a professional staff member are held at weekly intervals. The topics discussed follow a systematic curriculum which is directed toward increasing their understanding of the needs and problems of the children who are in their care. These discussions are frequently supplemented by training films on subjects of appropriate content.

The houseparents, while a non-professional group, are extremely important members of the therapeutic team. It is through their ability to establish a warm

relationship with the child that oftentimes the first steps are taken by the youngster in the direction of readjustment. Theirs, likewise, is a most trying duty for they must establish limits for the acting-out and rebellious child. Their function to serve as the controlling adult is a most demanding one and requires great insight, tact and patience.

For those children who are in the custody of the Department of Public Welfare a happy arrangement has been put into effect which is psychologically helpful to the houseparents in their care of the children. Purchases of clothing, which formerly were made on visits with the State social worker, are now made by the houseparents. It improves their status with the children to stand in the role of a providing parent as well as a controlling one.

Maintenance. Maintenance problems in a center in which the preponderance of patients are hostile, aggressive, destructive and acting-out is a very considerable one. This work is done by the plumbers, carpenters and grounds men who function for the entire institution. There are three cooks for the children in the cottage system and two helpers. The food is prepared for the Elbert children in the central dining room. The Housekeeper is responsible for the furniture and appurtenances of the cottages and tours this section regularly to insure that the buildings are properly maintained and that the needs of the children and houseparents are promptly met. A laundry located on the grounds takes care of the children's clothing and the bed linen and collect and distribute the laundry on a regular schedule.

Staff Consultants. Regular weekly and monthly clinics are held at the Center. As a result of this the children may be referred where necessary to specialists in internal medicine, dermatology, urology, general and orthopedic surgery, roentgenology, orthodontia and dentistry.

Research. The Center employs a full-time Coordinator of Research who works with staff members in the preparation of papers and on statistical studies. She is a well prepared specialist in child development and was a research assistant at the University of Chicago. At the present time her principal concern is with the completion of a five-year survey of children who were treated and discharged from the Health Center. This is a study which we regard as being most important to serve as a critique of our work and as a guide to future alterations or modifications of the various elements of our program. It is her responsibility to assist us in reorganizing our clinical record system and our methods of recording.

VOLUNTEER PROGRAM

The volunteer program throughout the entire Center is a very active one. Many individuals and organizations contribute time and special skills to its operation.

Through early experience at the Center it became very apparent that in the selection of individual volunteers and organizations to work directly with our children it was necessary that we have a staff member who could interview the various people and organizations to determine their reasons for wishing to work with the children and their genuine capacity to do so. The position of Coordinator of Volunteer Activities was created and this position has now been filled for the past two years. The Coordinator screens, orients and arranges, where necessary, for special training of volunteers for their activities at the Center. She likewise arranges schedules so that the program is functionally adapted to the basic activities program of the children. Over the past year 5,000 hours have been given to the entire Center by individuals and organizations. A considerable percentage of this activity has been carried on in or for the disturbed children's section. 26 organizations have helped with the recreation program, sponsored cottages, given parties, outings, dances, musicals, and theater entertainment. One of the most gala affairs for the children which is held at the Center is the spring lawn fete in which a number of organizations band together in a cooperative effort. Another group spon-

sors a picnic and circus which is attended by all the children at the Center.

TREATMENT

The treatment program stands upon two interrelated bases which includes the simultaneous study and treatment of the child and his parents or their surrogates. Through this dual approach, the child is helped to understand his problems, conflicts and fears and is assisted in moving to a more mature level of adjustment. Concurrently, the family is being given insight into the situations and relationships which produced the disturbance in the child. In this way, they are enabled better to understand him and to meet his needs and, upon his return home, to operate as a more efficent and happy family group.

The more important basis upon which this work is done with the child is through individual psychotherapy. Children are seen either in the therapist's office or out of doors or in a playroom. Interviews are conducted with a frequency to meet the needs of the child or the necessarily heavy schedules of the therapists. All of the therapists are dynamically oriented. Following the establishment of a relationship, treatment proceeds at the tempo which the situation permits and new insights and understanding of the child are discussed at frequent meetings with the houseparents and other residential workers.

Staff conferences are held daily at 11:30 A. M. during which time the problems affecting the various children are discussed. Attempts are made to evaluate the behavior of certain children and the motivations behind it. At this time many disciplinary problems are brought to the attention of the staff. Insofar as the therapists strive to eliminate themselves from a disciplinary role, ways and means of supporting authority and the communication of these decisions to the houseparents and other staff members are effected. Supervisory conferences are held regularly with the director of treatment by the therapists.

The second foundation upon which treatment is built is through the experience of living at the Center itself. In this environment regularly scheduled activities give form and purpose to the day. Evidence of authority and limits are held before the child but likewise considerable permissiveness and tolerance are encouraged. It has been our experience that therapeutic benefit to the child derives from the maintenance of a secure environment in which as many elements as possible are kept consistent and predictable. Within this environment he is able to establish relationships with adults who understand him, accept him and are willing to be helpful. The role of the cottage parents and the teachers in this environment can not be overestimated.

Insofar as changes, which are occurring in the child during individual psychotherapy, spill over onto and find expression within the cottage and recreation areas, the therapist must confer with houseparents and recreation personnel in order to forewarn them of possible acting-out or manifestations of testing behavior.

THE DAILY ROUTINE

During the school year all the children attend school at the Center in the various sections to which they are assigned following diagnostic staff meeting and examination of the school record.

The day begins at 6:45 and the children attend breakfast by cottages in the dining rooms assigned to them. Following breakfast they return to their cottage and take care of the housekeeping, tidying up their rooms, making their beds, etc. They then report to their classes at 9:00 and do not return to the cottage until 11:30. Following their luncheon there is a brief recreation period and they report back to school at 1:00 and then are dismissed to recreation at 4:00. Dinner is served at 5:00. Following this there is a recreation period and visits to the commissary by cottages. During the evening there are games and television or discussions in the cottages or visits by volunteer groups, and the children retire at 9:00.

RELIGIOUS OBSERVANCES

Regular religious exercises are held in

the Center chapel for the children on Sunday. Catholic services are at 8:00. Protestant services are at 2:00. There is a Pastoral Counselor on the staff who has an interview with every child admitted to the Center to determine his religious background and his spiritual needs. There are two chaplains in addition to the Pastoral Counselor who pay regular visits to the Center and who have discussion groups with the children and who participate in the staff meetings. Their mature judgment and familiarity with children's problems have made their contribution to the conduct and policy making of the Center most valuable.

RECREATION

There is an organized recreation program during the regular school year and during the summer months a much more extended one which is carried out by college students and those teachers who work during the summer months. All types of organized activities are carried on and various competitive activities are entered into with outside organizations. The Center children have their own swimming, baseball and basketball teams and have scheduled meets and games both on and off the Center during the appropriate season.

METHODS OF CONTROL

The staff has set up certain limits within which the children should operate. While transgressions are handled as much as possible with acceptance and a willingness to give further explanations and counseling, it has been noted that definite indications of disapproval by the environment are imperative in the control of the children. Physical bounds within which the children must live and limits upon displays of hostility both physical and verbal have been established. Offenses against these rules, while treated within the general frame of limits, is modified by the individual situation. In order not to overburden the child with negative prohibitions certain positive aspects of the disciplinary program have recently been explored and are about to be put into effect. These include passes which will permit children to go from one activity to another without supervision and to have certain additional privileges in regards to commissary and swimming which are not enjoyed by the other children. It is hoped that when this formal recognition of good behavior is put into effect the children's positive response will prove its value.

HEALTH PROGRAM

All the children at the Center are followed carefully from the physical standpoint. Height and weight charts are kept on a monthly basis. Semi-annual examinations are made. Necessary medical examinations are performed promptly and indicated clinical studies are carried out either at the Center or at hospitals designated by the consultant. A regular immunization program is in effect. Facilities are available for the isolation of contagious cases.

COMMENT

At the recent A.M.A. convention in San Francisco, Dr. Harry Bakwin stated that the growing problem of juvenile delinquency was due, in part perhaps, to the modern psychiatric methods of indoctrinating parents and of handling children. He indicated that the emphasis upon understanding and acceptance had so outweighed the emphasis upon discipline that the children had grown up without any inner control. This is a very serious indictment of the psychiatric approach to the care of disturbed children. We are frequently confronted with criticism of our methods and theories by people whose opinions are based upon inadequate information or are emotionally determined. When a physician of the stature of Bakwin, who has occupied an important place in the field of child care during the last twenty years, offers criticism, it must be heeded. Undoubtedly certain doctrinaire attitudes are apparent among some child care workers both professional and non-professional. Nevertheless, in justice, it must be recognized that, by and large, the workers in the field of child psychiatry are focusing their attention on working out practical methods and a sound theoretical basis for their therapeutic efforts.

It has never been the philosophy of the Center to deprive the child of those necessary external supports which would aid him in developing inner control. To accomplish this necessarily presupposes established controls in the environment. It is perhaps in the blending of modern concepts of treatment with definite ambient limits that we can most effectively assist in the child's growth and development. The science of child psychiatry is so young that its practices and principles are undergoing expansion and reformation. It is very apparent that time and experience and the attitude of scientific objectivity are developing sounder and clearer insights into the problems of the maladjusted child. It would, therefore, be most unfortunate to have any approach to the treatment of disturbed chilldren crystallized prematurely and thereby work to the detriment of the child and to the disadvantage of child psychiatry.

We recognize that we are working in an area which may still be justly regarded as a clinical frontier. By maintaining a scientific capacity for self-critique, by keeping abreast of the most recent advances in therapy and even through the experimental usage of the trial and error method we will ultimately evolve a therapeutic modus operandi which will be flexible, practical, and imaginative, and specifically applicable to the needs of our children.

EXHIBITIONISM

An Unusual Case History

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The perversion of exhibitionism comes to the attention of the authorities more frequently than most of the other "psychopathies." Also it is more narcissistic than the other partial instincts. Its erogenuous pleasure is always connected with an increase in self esteem, anticipated or actually gained through the fact that others look at the subject. This gain is used by the subject as reassurance against castration.[1]

This formulation has been borne out time and time again in the experience of the writer; and it is the fact that this particular case did not bear out this formulation which induced the writer to report it.

As noted above the usual exhibitionist must be seen and must feel that he is seen to produce the desired affect. One patient specifically stated that he exhibited only in the dark or at a great distance and that if he were seen the satisfaction was lost. At this point the writer felt that our patient could derive satisfaction from the fantasy of being seen, and that the actuality of being seen was in itself too dangerous to afford a pleasurable experience.

However, the fact that the patient revealed other perverse activities threw a difficult light on the subject and revealed sadistic and masochistic components. Thus, it was learned that he had at one time been convicted and punished for having telephoned a woman and made lewd remarks to her. Other pathologic impulses consisted of gambling with both his own and his wife's resources until he lost all he had. He took no pleasure in the gambling, rarely ever troubling to look at horse races, but contenting himself instead with waiting outside the track for the results. Further, he complained, he often felt compelled to lie even in situations where the truth would not involve him in any particularly painful situation. This was particularly true where women were involved.

It should, however, be noted that the patient's chief complaint, which he brought to the writer, at the suggestion of an attorney, was his exhibitionism. He felt a good deal of anxiety about it and attempted to ward off guilt feelings by rationalization and projection. Thus, he made a point of denying ever having been unfaithful to his wife while living away from her, i.e., in the Army, and he severely criticized some of his friends who "chased around."

The patient was a white male of athletic appearance in his late thirties. He had been married, although he was, at the time he

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1. Fenichal-Psychoanalytic Theory of the Neuroses.

was first seen, separated from his wife and two small boys. He was of better than average intelligence.

The Rorschach revealed him to be an individual with a compulsive ego structure, with his feelings being absorbed by a strong fantasy life. At times these (feelings) overwhelmed the ego and resulted in blind acting out. The content of the fantasies showed little enjoyment of actual heterosexual relations. His wife's fear of pregnancy added to his difficulties. He was hostile to his wife and feared retaliation.

His background revealed little closeness to either of his parents or to his three older siblings. He initially described them as "good Christians" and showed some resentment toward his mother.

Patient had been married early to a girl of about his age, who, it is suspected, came from a somewhat higher social stratum. He went overseas to active military duty almost immediately after the marriage. After his return he lived with his wife for a short period of time and then became involved in a business venture which took him away for a considerable period of time. It was during this period that patient fell into the arms of the law because of his perverse telephoning.

Although it was the writer's impression that the patient had actually spent more time away from his family than the business commitment warranted, this was never verified. The patient appeared to be making a conscious effort to meet the responsibilities of a family man and to love his small sons.

He felt his sex life was unsatisfactory. He practiced coitus interruptus without orgasm and sometimes obtained release from sexual tension by masturbation.

After having given much of the above noted data in a relatively few interviews, the patient developed a considerable degree of anxiety, apparently related to his having revealed so much hostility toward members of his family. He again attempted to avoid guilt feelings by rationalization and denial. He spoke of his parents as "letting him come and go as he pleased." He said his wife treated him the same way, even though he had previously complained that she constantly questioned him about his money and what he had done with it. Although he was referring to small sums of money which he used for his day to day living the suggested relationship to his gambling was noted.

He spoke of the fact that he got along well with his officers in the Army, but that when he was criticized he could not show his anger but covered it with a facade of complete passivity. Again he spoke of his wife in the same way and "wondered why she didn't supervise him more closely."

This patient was followed for a period of less than one year at weekly intervals. He developed considerable insight into his hostility to, and fear of, his wife and other women as the motivating factor of his perverse activity.

It might be said, in conclusion, that this man's exhibitionism took on the characteristic of a pre-genital i.e., anal sadistic activity. He attacked "castrating" women as a defense against the treatment he feared.

Although he has not been seen by this writer in several years, it is felt he was able to make a satisfactory adjustment with this relatively brief therapy.

SOCIOPATHIC PERSONALITIES

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In adolescence the idea that a criminal is a sick man rather than an evil one has been one of the chief court room issues of modern times. The ancient, stubborn mass of doctrine known as the law has understandably been slow in giving ground to the sick man theory. The latter is revolutionary even if it is more than a hundred years old.

The theorists—medical psychologists—have not enjoyed much public sympathy. Popular understanding has been clouded by their professional vocabulary and the fact that doctors, like everybody else, are apt to disagree. The layman often finds it hard to grasp how one psychiatrist can

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find a criminal mentally ill while another expert is apparently willing to send him to punishment and prison. The criminal law was built on the idea of punishment for itself, and as a deterrent to further crime. It largely represents out-worn morality. Psychiatry works towards the cure of the criminal sick. It is moved to this, not only by humane feeling, but out of conviction that punishment does not deter crime.

Modern psychology since Freud recognizes the unconscious mind and understands that in the given individual there may be a welder of mixed inter-related aggressive drives between the conscious and unconscious—often turning on themselves. Some men may commit a crime because they wish to be in prison. The sternest prosecutor may be full of unconscious guilt. Men who are loud in talk of justice may deeply relish the sadistic elements in punishment.

Delinquency is the term used in reference to minor offences against the culture with which the individual is expected to conform. The condition of delinquency amongst juveniles is an ever increasing topic of interest among educators, the legal profession and psychiatrists. We recognize some basic considerations. First, hospitalization: the hospital in this instance is being used for the purpose of psychotherapy and by it hoping to increase the individual's education. Ordinarily in our public schools, we expect to serve each individual juvenile according to his capacity regardless of his race, religion, national background, social and economic condition of life or handicapping conditions of any kind; but the mental hospital is concerned with helping the delinquent juvenile patient by psychotherapy and teaching, to guide their conduct by reason, to use intelligence in reaching decisions rather than blind obedience, habit or prejudice and to acquire a knowledge of self and of understanding of the consequences of behavior. Another basic principle to be kept in mind is that delinquency is not a distinct or separate problem. Delinquency should not be considered as we consider a disease but rather as the symptom of a disease. Delinquency, like truancy or incorrigibility, is but a symptom picture of underlying conditions the roots of which may be found in the family life, the school adjustment or the environmental background of the community and sometimes in physiological and psychological aspects of the individual personality.

In dealing with this sociopathic problem from the standpoint of the mental hospital or any other agency, one deals with the problem of a symptom which may have any one or more of many different causes. Moreover in dealing with delinquency or any other symptom, one does not correct the problem until fundamental causes are found and corrected or alleviated. Even though some measures may temporarily allay the symptoms. We find by our experience in this hospital that many of these sociopathic juveniles come from broken homes or homes in which abuse, ill-treatment and cruelty instead of love was the order of the day. We find that the lack of ordinary parental attention to the youth has been a cause for the youth attempting to find his place in the sun to gain recognition from his fellow juveniles and to satisfy his gregarious instinct by associating with youth of like character.

The sociopathic individual, many times due to experience he has gained from the type of environment in which he was raised, has a deep feeling of being the under-dog and presumably the first law of nature; survival of the fittest takes charge. In his attempt to survive, he allows his gregarious instinct to have full sway and very early in life associates himself with his own kind. The old axiom proves true; birds of a feather flock together. But he is not usually satisfied to merely associate, in order to compensate for that feeling of being an underdog, he wishes to lead the pack and in doing so takes a great delight in performing an act which he considers one of bravery and this usually is the forerunner of petty crime; such as automobile theft, breaking and entering, and sometimes crimes of a sexual nature. He knows that the more daring the crime the greater prestige he

will have with the gang. This type of behavior regardless of its consequences seems to be paramount in his ambition. It is a feather in his cap, as far as his associates are concerned, if he has been arrested and convicted of a crime and has served a sentence in a penal institution.

It is noticeable while watching these patients when they are absorbed in watching television that they take great delight and also expound the ability of the criminal in the ordinary television detective drama. They take great delight in criticizing the shortcomings of the police. They seem to care nothing for good musical production or travelogues or political discussions. In the broadcasting of news events, there seems to be no events remembered or cared anything about except a crime that has been committed and the more severe the crime the greater delight they have in repeating the circumstances. This typ of individual when he first enters the Criminal Division of this hospital is arrogant, surly, noncommittal. He adheres to the secret code of the underworld: "don't tell them anything." However, after quite a time and with much pschotherapy, they do loosen up and portray the characteristics which have been mentioned above.

It is a noticeable fact that all their life has been consisted of mostly misbehaving; they can behave if they wish to although it may be quite a strain. It is noticeable that they make ideal patients if they have a promise of release in the future provided their behavior is above reproach. They are the type of person who expect much and give little or nothing. The word sympathy or affection is not to be found in their vocabulary. They often speak of their parents as one would of a casual acquaintance. Regarding their petty crimes such as petty thievery, they often give the remark back 'only fools work hard for a living.' It is the type of environment in which they were raised, the type of associates they have lived with, and the experience that petty thievery, when successful gives them the monetary value that probably two weeks of hard work would only equal. The morality of their act is not even considered. I'm happy to state that the majority of this type of patient discharged from this hospital have done fairly well; the minority have reverted to their old type and some at present are incarcerated in prison for repeated acts of a criminal nature.

The constant effort of society to try to induce the outlaw to live within the law must be kept going. We cannot expect one-hundred per cent successes but we feel that those successes that we do have are a just compensation for our efforts to lead the youths into a channel of life which will lead to good citizenship.

PSYCHIATRIC TREATMENT OF CHILDREN

By Means of the Total Environment

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The staff at the Governor Bacon Health Center is engaged in the treatment of children with emotional illnesses by means of milieu therapy, or treatment within a therapeutic environment. As has been described in a previous paper,[2] the emotional illnesses of children represent in effect, interference with growth of various aspects of the personality, or regression to earlier levels of growth. The purpose of the present paper is to discuss further the role of treatment-in-residence in bringing about this growth and to demonstrate with a case this "treatment by the total environment."

Certain questions may be asked at this time. What is the essence of residential treatment? What are the elements that bring about change in the emotional and personality structure in a child? Elements that enter into the developing personality are: personal identification, identification with parent-ideals, warmth of feeling, control of impulses, stimulation of curiosity regarding the environment, reality testing, group relationship, recognition of the worth of the self, gratifying accomplishments to promote self-esteem.

This growth comes about through the

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integrated efforts of an entire team. Milieu therapy[1] is the facilitation of growth by means of the living experience. Milieu therapy supplies the elements listed above in accordance with the child's ability to use them, in a setting where he is accepted in spite of his inabilities, where there exists the paradox of consistent control with a general air of permissiveness. It supplies continuous contacts with people. It provides the opportunity to utilize people in the environment as symbols of members of his family or of the homes in which he has lived. The child is free to experiment with various tools of mastery of his fears of relating to parent figures or social groups. He can practice using these tools. He can also practice meeting fearful situations (counterphobic work). A fluctuating balance of failure and success of individuals within the group removes the emphasis from his own failures.

In his experimental relationships with neutral adults, he finds them not threatening and he gradually modifies the intensity of the fear and hostility in the existent feelings toward important persons in his life outside of the institution.

In the following case we will demonstrate how various members of the "team" in the residential treatment center participated in treatment of a severely inhibited girl with schizoid traits. In this case there was particular emphasis on the recognition of the worth of the self, the maintenance of continuous contacts with people with modifications to suit the child's need, the provision of suitable individuals for parent ideals, stimulation of warm feelings, the provision of tools to exist comfortably in reality and some counterphobic practice in diminishing the intensity of guilt regarding sex.

Dora was a colored girl who was admitted to the Center at the age of 11½. Her home was described as disorganized and the children lacked the normal family conditions. The father was alcoholic and the mother irresponsible. Dora was the third of five children. The youngest child is reported to have died of neglect. Dora was first placed in a foster home selected by her parents when she was about 3 years old and subsequently was in two foster homes in the State Department of Public Welfare. She had reacted to her early environment by withdrawal and she is described as having been slow, apparently dull, unaggressive, docile, and backward. Not having been stimulated by maternal affection in her own babyhood, emotions within herself were not aroused and she appeared to have lower intelligence than was actually the case. While in her foster homes she developed some neurotic traits. She bit her nails until her fingertips were sore. She was continually poking holes in her clothing without apparently noticing that she was doing so. She was enuretic until the age of six. At 11 years of age she was molested sexually by a man in the community. Subsequently she was placed in another foster home. Dora reacted to these traumatic events by further denial of her emotions and by adolescent fantasies. The people who cared for her were impressed by her apparent lack of concern and understanding in spite of explanations. She made claims that a 14 year old boy and the foster father in the new home molested her and these claims were considered to be at least in part her own fantasy. Dora's accusations were too threatening to the foster parents and they were unwilling to have her remain there. She was then admitted to the Governor Bacon Health Center.

As we can see, Dora's life experience had been such as to provide sparse material for the full development of a personality. There was lack of affection throughout and therefore little stimulation for the development of warm feelings within herself. Her parents proved unworthy models for the child to desire to imitate, and the diluteness of feelings provided by the foster parents did little more. There was no father at all in the foster home where she remained the longest. She therefore had weak parent ideals to include in her growing personality. There also had been little to contribute to her own self esteem, and her final failure and shame undermined what little she had. She reacted to

her situation by withdrawing her feelings, denying them, and repressing her guilt. Her picture was one of schizoid tendencies. She could not form close relationships with anyone. Although she was in a cottage full of lively, acting out, emotional girls, she remained quiet and "good."

Her initial attempt at becoming a part of the group was completely frustrated and she did not have a clear picture of her own identity. When she tried to mingle she talked too loud, seemingly unaware that she was talking differently from other people. The first efforts of the house parent had to be centered about protecting her from the more aggressive children. She was then put in a selected group of negro girls for group therapy with a white male psychiatrist where she had further protection from group aggression. She initially tried to please the other girls, but could do so only by sharing her things with them and letting them impose upon her.

During this time the social worker (female) maintained a continuous but dilute sort of contact with her having regular appointments with her. The worker remained quiet, unobtrusive but friendly. (This type of contact often offers the least amount of threat to a shy person.)

After about a year, therapeutic effects began to be noted as a result of her school experience. She began to develop small beginnings of self-esteem because she was able to make better progress than some of the more restless children. Dora was able to utilize her reading ability to make herself more comfortable in the environment, as she could then withdraw from the group by taking up the pastime of reading. We note that this tendency could have increased her abnormalities, had other influences not been brought to bear. It was thus merely a shield to protect her during a trying time.

By the next year Dora was quite comfortable in the cottage. She could even mingle with the opposite sex. However, she was not really a part of the group, but remained in a neutral position. She continued to be immature for her age, a result of her resistance to growing up. At this point, another girl had become the victim of the rejection by the big girls in the cottage. A plan was then made with the house mother to use Dora to help bring this girl back into the group. Dora and one other girl were the only ones that did not reject Mary. The plan formulated was that the house mother would ask these two girls and Mary to join her in some simple activity such as sewing or playing a game, thereby involving the three in an informal group. The plan proved beneficial to all three. They had temporary protection from the group of aggressive big girls, while at the same time feeling included in a group themselves. This allowed time for the animosity of the big girls to become dissipated, while Mary was working through her problems with her own psychotherapist. The improved relationship brought about some improvement in Dora's ego strength. During this time Dora had been enjoying the pastime of drawing and was becoming very proficient. The admiration of the other girls proved another crutch in the easing of interpersonal relationships. Her school teacher helped to develop this ability and allowed her extra time for practice, thereby adding more material for improvement of Dora's self esteem.

In the next phase, Dora's conflict and guilt about sex had to be dealt with as she could not remain aloof from the situation around her, where she was surrounded by girls all developing interest in the boys. The house mother gave her as much reassurance to allay her feelings of guilt as possible as well as necessary instructions. Her house mother at this time and until the time of discharge was a warm, understanding colored woman in her late thirties, who had considerable personal charm.

By the time she was 14 she was integrating smoothly in spite of her personality weaknesses. She was beginning to show warmth of feeling and made friendly overtures to staff and children. However, she was too inhibited to express her individual preferences and she utilized her

artistic ability chiefly to make copies, being afraid to express her own ideas in art. An intensive investigation of the personality by means of the Rorschach test at this time still showed poverty of human relations, some strange responses and some sexual conflicts. She next began to respond to the efforts of her home economics teacher. Her achievements in sewing gave more ego support and the first signs of any narcisisstic gratification. Up to this time she had been quite sloppy about her appearance. With the combined aid of the house mother and the home economics teacher, she found some pleasure in improving her appearance and could even make herself presentable for social affairs in which the boys participated. While she was still inhibited with the opposite sex, she found this to be a superficial aid in conforming with social requirements. Another attempt of psychotherapy was made by the male therapist who had had the original group. This time, treatment was individual and was chiefly another step in making relationships. She became quite comfortable although unable to discuss the traumatic events of the past. The chief therapeutic work on her part was making pictures of boys and also of the therapist, (lessening the intesity of guilty feeling by repetitive activity). After several months the therapist terminated his connection with the Center and for the first time she showed some anxiety and unwillingness to discontinue a relationship.

Dora was able to continue improving on the basis of the segments of ego-structure that had been developed through the various persons participating in her total environmental treatment. Having demonstrated her ability to form some sort of a relationship she was discharged as improved at the age of 15 years and 9 months, going to a carefully selected foster home in which there were no boys. Through the combined treatment of the house parents, teachers, caseworkers, and psychiatrists, she has acquired some basis for self-esteem, some warmth and ability to relate to people, motivation to present a normal appearance and to integrate with society in accepted ways. She was not amenable to deep insight therapy and she still represses sexual feelings. She will probably continue to be a rather inhibited person but able to be comfortable with people and to find enjoyment in life. She is now one of the types of personalities which fit into our society and there is a good possibility that she will find her niche and be able to pursue a gratifying economically productive life.

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CURRENT CONCEPTS OF GROUP PSYCHOTHERAPY

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Group therapy as a method of treatment for psycho-neurotics obtained its greatest impetus during the last war. As early as 1907 Pratt applied group methods (class-lecture etc.) in the treatment of tuberculosis patients. In 1917 S. E. Jeliffe wrote "Psychotherapy and Drama." In the 1930's proposals were made for harnessing the emotional energies of prisoners by means of group activities. However, a pressing problem was brought about by the disproportion between the numbers of people needing help and the scarcity of adequately trained therapists to aid them. To overcome this discrepancy an attempt was made to help people in groups. The number of methods used ranged from lectures and vigorously directed groups to very permissive groups. It soon became apparent that what started out as an emergency measure, showed promise and in itself had potentialities and has since become accepted as a method of treatment.

The aim of group psycho-therapy is the same as in individual psycho-therapy, namely, to help the patient feel more comfortable within himself and in his environment.

Regardless of the methods used the following therapeutic processes take place in group psycho-therapy the same as in individual therapy although differing in

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minor elements. The aims are to affect libido redistribution, ego strengthening, adjustment of the super-ego and to correct the self-image. These results are brought about through dynamic factors of (1) transference, (2) catharsis, (3) insight, (4) reality testing, and (5) sublimation. It is to be noted that the foregoing factors are the same as those that are of use in individual psycho-therapy. However, there are many differences.

Transference is present in all therapies and is seen in its purest form, unilateral, from patient to therapist in psycho-analysis. In the less intensive therapies it is bilateral, that is, not only does it flow from the patient toward the therapist but also the therapist returns it in the form of empathy, interest and encouragement. In the group, the transference is modified still more by the presence of other persons. Early feelings inadequately repressed and memories concerning siblings as well as parents are activated. In the group we find transferences of a parental, sibling and a third type, namely, identification (Slavson). While identification is present in all transference, the group by virtue of its greater number of identification objects, offers opportunities not present in individual therapy.

One of the biggest differences in group therapy as contrasted with individual therapy is in the sphere of transference reactions. In group therapy, in addition to the positive transference to the therapist there must be a positive transference toward the group as well. When the transference to the group is negative for too long a period or is too intense, the patient cannot function and he either acts out or quits the group. In the group, the transference is usually diluted and the intensity for any one individual is lessened as the result of mutual support, reinforcement and group identifications.

Catharsis is the same in group as in individual psychotherapy. The type of catharsis in the treatment of psychoneurosis of adults is verbal. It may occur as (1) free association, (2) associative thinking, (3) directed, (4) induced, (5) forced, (6) vicarious. The method of free association is the same as most frequently used in psycho-analysis. Associative thinking such as productions related to current experiences and acts are expressed. This method finds its greatest use in guidance and counseling. Induced and directed catharsis can be employed favorably in selected cases. All of these forms are present in group therapy, although the forced form is not used in groups. Of all methods the induced form is inherent in group therapy. It is an emotional contagion. A statement of one sets off a chain reaction in others because of the common interests and difficulties. Vicarious catharsis is of prime value to certain patients. It is contingent upon similarity of problems and capacity for identification. It can be conditioned by similarity of personalities as well. Forced catharsis is not to be permitted in group therapy and when one patient tries to force another beyond his readiness, he must be interrupted. Mutual support, identification, universalization and target multiplicity all tend to promote catharsis in the group.

Insight is conditioned by (1) emotional maturity, (2) elimination of ego defenses, and (3) intellectual comprehension. It is acquired in groups not only through interpretations of the therapist but also by interpretations offered by other members.

It is in the field of reality testing that group psychotherapy really excels over individual therapy. The patient in the group may be encouraged to regress but he has the opportunity of continually testing his associations on the other members. The group becomes a tangible and pressing reality to each member. He has to learn to deal with his own dislikes as well as the dislikes of others, to accept attacks of others and to control his own aggressive acts. There is less chance for the patient to misinterpret or distort his reactions.

Sublimination should be arrived at through a gradual diminution of primary drives in comparative freedom and as a part of reality testing.

Groups supply opportunities for ways of escape from participation not readily

found in individual therapy. Absentism is easier in a group since guilt feelings of the resistive patient are not too easily aroused (group will go on anyway, so he tells himself). Distraction is also easier in a group; a member may laugh, tell a story or otherwise interrupt the discussion. Abruptness (breaking in on another before he is finished), another form of resistance is also easier in a group than in individual therapy. Silence, general or selective, may be shaken by a direct question from one who notices the prolonged silence. Acting out is discouraged in any adult group.

The group itself consists ideally of 6-7 individuals. These individuals should be picked in such a way that it molds almost into one personality. In other words, personalities should be alike in as much as possible so that the therapist instead of treating 6 different individuals would be able to treat the 6 as one. Another way of stating this is that the nuclear problems of the individuals are similar and must have some common meeting ground. It is disastrous in a group of neurotics to include a character neurosis. Severe or moderately severe obsessive-compulsive individuals do not do well with hysterics, for example. Psychopaths, paranoid personalities, obsessives (unless it is a group of obsessives), tend to disrupt the group. Alcoholic or drug addicts do not do well in general groups because they do not form a common bond with the others. It goes without saying that psychotics should not be included in groups of neurotics, because their associations would tend to cause too much anxiety among the others. The reasons for non-mixture can readily be seen if the group is to develop.

As in individual therapy, the patient should not join for fun or because he is interested, but because he recognizes and accepts the fact that he needs help and is willing to work to achieve a better adjustment.

In summary the aims of group therapy are the same as in individual therapy, that is, to help the patient feel better, by a redistribution of libidinal energy, ego strengthening, adjusting the super-ego and correction of the self image. An attempt has been made to describe briefly the dynamic mechanisms by which changes take place as well as touching upon the size and character of the group.

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POSSIBLE ORGANIC BASIS FOR A SYNDROME

Reading Disability, Hyperactivity, and Behavior Problem in Boys

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This paper is based on random observations recurring with sufficient frequency as to seem to represent a syndrome. There is no pretense that what follows is in any way scientifically validated, rather an area for possible research and further clinical observation is being suggested.

Observations were made of children seen both in the Mental Hygiene Clinic and to a limited extent, in my own private practice. In the past two years I have seen at least 13 cases—11 boys and 2 girls—aged 7-14, who can be categorized as presenting this syndrome. All were of average intelligence (however, in an earlier day several of them could have been tabbed as stupid). At home and school they were regarded as being restless, irresponsible, overactive, thoughtless, but not mean. The older boys tended to have been delinquent. Six of the boys could not read, all thirteen had little interest in reading and read, at best, below grade level.

Neurological examinations were negative except for a tendency in some to poor psychomotor coordination.

My collective impression of the social histories is that the higher proportion had what could be considered poor home environments with plenty of psycho-pathogenic possibilities, but this was not always

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the case. Most of the children had siblings who were not similarly affected. There was no clear cut unequivocal history of organic trauma. Restless, overactive behavior tended to have been noticed by parents prior to the start of school—with several the child in question was regarded as having been overactive from the time he learned to walk.

In the psychological test results no child was rated as defective. Nor were there any test signs of organic impairment. No consistent personality patterns seem to have been evident. However, there was a consistent tendency for verbal scores on the Wechsler-Bellevue test to be down and performance scores to be up. In the Wide Range Achievement Test (Jastak) reading and spelling scores were always low. Arithmetic usually was close to grade level.

In the psychiatric interviews gross abnormalities were few. They all related well, tended to be rather aggressively friendly (forward), were eager for and responsive to attention. Restlessness was evident as pressure developed or sustained activity was required. Distractibility and aggressive attention getting behavior tended to be more evident in a group situation. The two most consistent features were a denial of the reading difficulty, or at least a denial of concern, and a restless reaction to attempts to force concentration.

Electroencephalograms, where done, were consistently abnormal. The abnormality tended to be diffuse—that is not localized—and presumably not diagnostic of any definite clinical condition.

In several cases amelioration of hyperactive behavior and an increase of the attention span seemed to follow the use of "suppressive medication" (dilantin or phenobarbital). In one case improvement followed amphetamine medication. At least two were helped by psychotherapy alone.

An hypothesis which assumes an organic factor to be of central importance in the genesis of this syndrome follows: It is suggested that these children have sustained minimal brain damage, either prenatally or in infancy, of a sort that has caused no detectable neropathy, but which has resulted in a lowered capacity to sustain psychic tension. An alternate hypothesis having similar significance would be that in these children there is a congenital deficiency in their capacity to sustain tension and that this defect can be correlated with altered electro-cortical activity demonstrable in E.E.G.

The eventual clinical picture would derive from the above genetic condition in a fashion something as follows: (1) Organically decreased capacity to sustain psychic tension; (2) lessened ability to restrain the primitive drives as is required in the "house-breaking" processes of the preschool years with resulting slowness to conform to parental expectations of good behavior; (3) resulting from this there is an increase of parental efforts at restraint and a decrease in the rewards they give out. A circular situation is set up—which will be continually repeated in school—the child can't hold still, resulting in environmental (parents and school) pressure or restraint, which actually increases the inner urgency or pressure to discharge in restless activity, which, in turn, calls forth environmental pressure. The only surcease lies in unregulated play where a switch can be made to a new activity as soon as environmental pressure starts to increase the inner pressure or tension. This escape in play tends to be cut off when school starts. In school, reading above all else in first grade requires some ability to concentrate, that is, to sustain tension. Failure for the child to acquire this skill practically ensures that ensuing school years will see the problem maintaining itself and discharge of tension being accomplished in the only way he knows. Restless, unregulated activity will be perpetuated.

The dubious quality of this hypothesis lies in the fact that there is no clinical evidence presented which would indicate that the origin of the crucial restlessness is organic rather than psychogenic. I believe this applies equally to the disordered E.E.G.s found here, which as far as the

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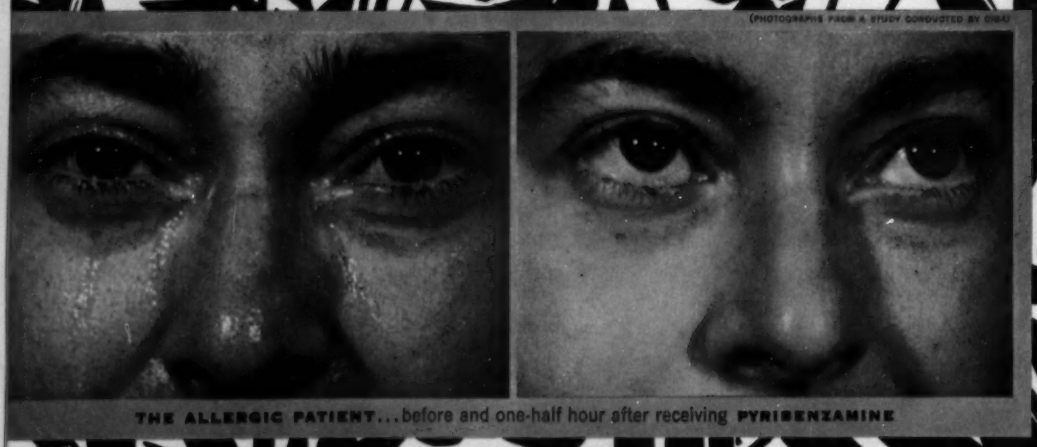
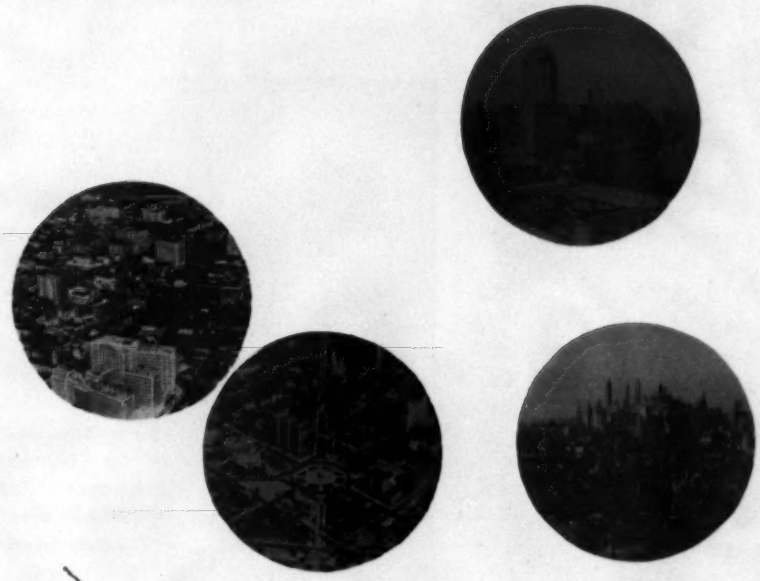


(PHOTOGRAPHS FROM A STUDY CONDUCTED BY CIBA)

THE ALLERGIC PATIENT...before and one-half hour after receiving PYRIBENZAMINE



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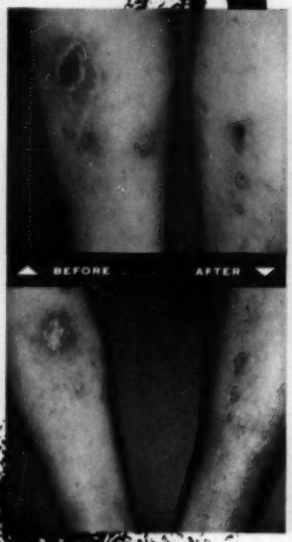
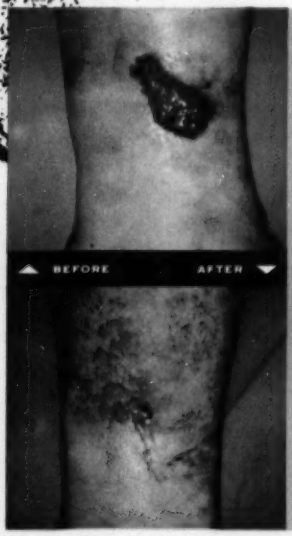


BILATERAL ARTERIOSCLEROTIC ULCERATION in patient age 65. At start of Priscoline therapy; ulcer, right leg, 1¾″ x 1¼″; ulcer, left leg, ½″ x ½″. With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



HYPERTENSIVE ISCHEMIC ULCER of right leg in patient age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

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present state of knowledge is concerned might be evidence only of a functional alteration of electro-cortical activity.

Moreover, no sustained attempts at deep psychotherapy that might uncover the psychopathological roots have been made. One other difficulty is that there are five times as many boys as girls among my cases. I attempted to explain this away with the speculation that the greater biological and cultural push toward activity in boys combines with a potential organic deficit in self-restraint, resulting in the greater frequency of the appearance of this syndrome in boys.

However, should this prove to be a true syndrome that does have at its base an organic deficit in the child's ability to concentrate, the clinical implications would appear to be important. Particularly would this be so if the syndrome could be recognized in the pre-school years when prophylactic steps might be taken against the development of a reading disability with its increasingly serious sequela.

SUMMARY

It is suggested that reading disability, hyperactive behavior and altered electrocortical activity occur together with sufficient frequency as to constitute a syndrome most apt to appear in boys. It is hypothesized that an important pre-condition of this syndrome is some sort of organic deficit in the central nervous system which resulted in a decreased capacity to sustain tension (and hence, pay attention), in the children manifesting this syndrome.

A FAMILY STUDY OF HUNTINGTON'S CHOREA

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A study of a family may reveal several individuals in the family or relatives of the family suffering from the same disease or from some other psychiatric or emotional disorders. We have under consideration one such Caucasian family. At present there are two members of the family hospitalized at the Delaware State Hospital. A third member of the family, who had been a patient here, improved and is now on trial visit.

The father, age 67 years, is a widower. He was hospitalized here in 1949. The commitment papers gave the duration of his illness as five years, in which he showed choreiform movements of the face, neck, upper and lower extremities, with a choreic gait. Mention was also made of a peculiar facial expression and a slurring speech. His wife had died several months before his admission to this hospital.

He was described as always having had a rather cheerful disposition, which continues in spite of his present physical condition. A neurological examination in 1941 revealed a diagnosis of Huntington's chorea. He had reached the point that he was absolutely unable to take care of himself. He would not bathe, dress or shave. He had a tendency to walk away at times.

The family history disclosed that patient's sister had been hospitalized in a mental and nervous institution in New Jersey suffering from Huntington's chorea. She died six years before patient's admission to this hospital.

Only one etiological factor in Huntington's chorea is known, namely, heredity. Direct and similar inheritance is the rule, the disease appearing as a dominant; it can pass for generations uninterruptedly, but no doubt at times the carrier of a dominant may fail to develop that trait, or do so in some modified form.

In Dr. George Huntington's original description of the disease, he stated, "The hereditary chorea, as I call it, is confined to certain, and fortunately a few, families and has been transmitted to them, an heirloom from generations away back in the dim past. . . . It is attended generally by all the symptoms of common chorea, only in an aggravated degree, hardly ever manifesting itself until adult or middle life, and then coming on gradually but surely, increasing by degrees and occupying years in its development, until the hapless sufferer is but a quivering wreck of his former self."

Huntington's chorea is more common in men than in women. There are three marked peculiarities in the disease: (1) its

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hereditary nature; (2) a tendency to insanity and suicide; (3) its manifesting itself as a grave disease only in adult life. The disease is distinguished by the union of persistent and progressive choreic movements, with deterioration of the mind, and further by its heredofamilial incidence.

The father of the present family under study at the Delaware State Hospital had been a painter by trade and worked at same as long as he was able. He became incapacitated in about 1920 and the family was aided by the Family Society from 1920 until 1941. There were eight children. One child died of convulsions in infancy. One of the daughters was treated at this hospital in 1949 to 1950, suffering from chronic alcoholism and diagnosed Korsakoff's psychosis. Another daughter has been before the Juvenile Court charged with immoral conduct and delinquency. A son was examined at the Mental Hygiene Clinic in 1943, having been referred by the Juvenile Court on a charge of larceny and forgery.

Another son, age 30 years, is also at present a patient in the Delaware State Hospital. He showed psychopathic traits from early childhood, having been arrested on five different occasions on larceny charges. He is a muscular type of individual with rigidity of the shoulders and neck. He also has a peculiar, partially spastic gait. His speech is jerky, his movements choreiform in character and there are some incoordinations in his voluntary movements. His hands and fingers are held in awkward, rigid positions. While not actually a case of Huntington's chorea, he suffers from a neurological condition characterized by similar or modified symptoms.

As Dr. Huntington observed originally, the eligibles who did not develop the disorder of Huntington's chorea, nevertheless, were peculiarly excitable and more than normally responsive to nervous strain. Roughly speaking, from one-quarter to one-half of a sibship may be expected to become choreic. The original postulates of Huntington's chorea hold good today, namely: The appearance of the disease only in adult life; its chronicity and gradual development; its following a direct line from parent to offspring, and when this line was broken, its failure to reappear in future generations. Thus, when once started, the disease never relaxes its hold. Remissions or temporary alleviations seldom, if ever, interrupt its sequence.

None of the children had a normal home life. The mother was a rather meek woman but she was hard-working and because she had to work, was not in the home. The father, moreover, because of his condition, could not supervise the children. They lived in crowded and cluttered quarters in the city yet they seemed to be a closely-knit family.

In summary, this has been the study of a family whose members have various neurological traits. The hereditary aspect of Huntington's chorea has been shown. Although a familial incidence is characteristic of the disease, it was seen that not all members of a stricken family develop the disease. It was also shown that one member of the family, who is at present a patient at the Delaware State Hospital, although not presenting sufficient evidence at this time for Huntington's chorea, nevertheless, has mannerisms, choreic movements, etc. that resemble the disease and probably may represent some modified form of it. Some regular components of Huntington's chorea as well as other neuropathic and psychiatric traits were found in this particular family.

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DEPRESSIVE REACTION MASKING NEUROSYPHILIS

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The patient (J. H.) to be discussed was born on August 16, 1892 in Ireland. No information was received about his family history or about his birth and early development. He came to the United States in 1920 and until about 3 months prior to his admission here, he worked as a outler

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and gardener. He had good references and excellent record. It is stated that patient was always healthy. Patient himself claims that in the spring of 1953 he developed a left ankle edema and has seen a private physician in Connecticut, who prescribed bed rest for him. This left leg "acted up" again the fall of 1953, then patient received some kind of treatment from a chiropractor.

The prepsychotic personality is described as happy and quite outgoing. He always wanted to make people happy and was constantly buying gifts for the children of his friends when they had birthdays, weddings, etc. His friends were mostly men. He likes to play cards or chat with them. His hobby was horse racing and it is estimated that patient lost between $25,000.00 and $30,000.00 on horses since he had been in the United States.

In February, 1954 patient resigned from his job. In the following months patient gradually became depressed, made debts. In early April, 1954 patient contacted one of his friend telling him that he wanted to give himself up to the police because he did not pay his income tax for the past 3 years and because of this, the police were looking for him and he would go to jail. Patient also related to his friend that he made suicidal plans. The friend became alarmed, called on a private physician, who then referred patient to a local hospital on April 19, 1954. There a consulting psychiatrist found the following symptoms: depression manifested by guilt feelings about not working and pecuniary matters, agitation and anxiety, feelings of unworthiness, constipation, suicidal ideation. Patient was guarded, defensive and difficult to elicit information from. However, he admitted that he had been treated for gonorrhea at the age of 26. He also found that patient had a delusion about suffering from pediculosis and that some of the patient's replies were irrelevant and incoherent. His diagnostic impression was Involutional Psychotic Reaction and recommended commitment to Delaware State Hospital which was done on April 24, 1954.

Chief complaints were: "I have suffered from constipation, and I feel guilty." The main findings of the admission physical examination were: Patient has a pyknic habitus. His blood pressure was 192/108 in supine position. Pulse rate was 98, regular. The neurological findings revealed that the right pupil was larger than the left and it did not react to light. The finger to finger and finger to nose tests showed marked past pointings. The abdominal and cremasteric reflexes were absent. There were marked tremors of the hands and fingers. The gait was shuffling. The Romberg and Babinski signs were negative. The speech was retarded and slow. The impression was hypertensive arteriosclerotic heart disease, compensated, and syphilis of CNS to be ruled out.

During the diagnostic interview and mental examination, patient was sad, retarded, friendly and cooperative. He admitted that recently "I tried to choke myself with a towel. I am a bad Catholic. I wanted to die. I feel guilty. I committed a lot of sins, like masturbation and homosexual acts." Beside suicidal ideas, hopelessness and guilt feelings, patient also expressed some grandiose paranoid ideas like, "everybody will be against me because I will destroy this place—when the laxative works I will mess up this place so they could not clean it up." The tentative psychiatric diagnosis on admission was involutional psychotic reaction, but syphilis of the CNS to be ruled out. Shock treatment was suggested if there would be no contra-indication. Laboratory examinations, blood serology and electrocardiogram were requested.

A psychological testing was done on April 30, 1954 in which the short form of Wechsler Bellevue test revealed that patient showed a good deal of psychomotor retardation and the intellectual functioning was average. In the projective testing (Rorschach, Drawings) the patient's responses were "very sparse and showed a lack of drive, energy and motivation. There was also evidence of blocking and depression. He is so preoccupied with himself that there is little external contact being made."

The laboratory examinations revealed the following: the first 3 urine analyses

revealed specific gravity 1020-1221. Blood count on April 29, 1954 revealed 4.61 RBC; the hemoglobin was 93; the WBC was 9600 and the differential count was within normal limits. On the same date, the blood Wassermann and Kahn reactions were negative. The icterus index on May 11, 1954 was 5. and blood cephalin was negative on the same day. X-rays of chest and skull were normal. The electrocardiogram from May 12, 1954 revealed: "AV rate of 107; normal sinus rhythm. P waves are upright in all three leads. PR interval is .16; GRS interval is .08; ST interval is .24. T waves are upright in leads I, II and III. Deep wave in CR 1; high R waves in CR 6. The conclusion: Sino-auricular tachycardia. The tracing is probably normal."

During the month of May, 1954 patient's mental picture did not change. He continued to be depressed, was seclusive, but ECT was postponed because the requested tests were not yet completed. On the evening of May 26, 1954 patient complained of pains in the left leg. Examination on May 27, 1954 revealed that the left leg from the ankle up to the thigh was considerable swollen, the skin shiney and hot. The impression was of thrombophlebitis, and patient was placed on penicillin, 300,000 units twice daily intramuscularly. It was noted that patient was less depressed than on admission. Prothrombin time on May 28, 1954 revealed 13 sec. with the control also in 13 sec. In the following days under the penicillin treatment, patient's leg condition improved, however, he developed urinary and anal incontinency. On June 10, 1954 when the leg condition improved enough, a spinal tap was done which revealed 1 cell; the protein was 52 and the Wassermann reaction was strongly positive. The gold curve revealed 3322110000. On that day patient's penicillin was raised to 600,000 units b.i.d. From May 27 until June 16, 1954 inclusive, patient received 12,000,000 units of penicillin. On June 17, 1954, the day after the discontinuation of the penicillin treatment, patient's spinal fluid revealed that the Wassermann was still strongly positive, and the gold curve was 3221000000. A urological consultation pointed to the central origin of patient's incontinency.

On June 18, 1954 patient was presented to the staff and the diagnosis of chronic brain syndrome, associated central nervous system syphilis (meningoencephalitic type) with psychotic reaction was made. On July 8, 1954 patient was examined by the neurological consultant who found: "mild hypertensive arteriosclerotic changes in the eyegrounds, the right pupil dilated and react sluggishly to light. Tremors of the outstretched hands, slight weakness of both lower limbs on active motion but gait is normal. Generally overactive, deep tendon reflexes with a left Babinski sign. The neurologist confirmed the diagnosis.

At present day (July 15, 1954) patient's mental picture is improved to the extent, that he expresses no guilt feelings, or grandiose, nor paranoid ideas. He is rather cheerful at times, his memory is fair. However, he is still somewhat seclusive and still shows lack of drive.

SUMMARY AND COMMENTS

A case of general paresis is presented in which the patient showed initially a psychiatric picture of deep depression with some grandiose and paranoid ideation and some neurologic signs. While patient had an intercurrent disease, thromobophlebitis of the left leg, he developed urinary and anal incontinency. Although patient had a negative Blood Wassermann and Kahn reactions, his spinal serology showed positive Wassermann reaction and a mid-zone colloidal curve.

The important advancements in the diagnosis and treatments of syphilis, together with improved public health service, make it rare to see nowadays a case of general paresis. Because of this rarity of syphilis of CNS it is important that the slightest neurological signs, which might be masked by a psychotic syndrome should be followed up with complete serological testing and neurological examinations.

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PSYCHOSIS FOLLOWING BROMIDE INTOXICATION

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The recent literature reveals that the number of admissions of patients with bromide intoxication to mental hospitals has increased over the past years and attributes this fact to the greater restrictions in the dispensing of barbiturates.[1]

The patient to be discussed was transferred November 6, 1952 to Delaware State Hospital from a general hospital where he had been admitted for possible pneumonia. The report from this hospital stated that patient had been confused and hallucinating since his admission. A tentative diagnosis of myocarditis and pneumonitis was made but the x-ray report of the lungs stated only that there was a mild density in the lower lobes, which may have been partially in the soft tissues and partially due to artifacts. It stated further that a mild, inflammatory process could not be ruled out for sure. The report from the hospital stated further that patient's physical condition improved after administration of oxygen and other medications, but that the mental condition failed to improve. Therefore, he was commited to Delaware State Hospital.

Physical examination on admission revealed a well-developed but only poorly nourished, white male, somewhat dehydrated, with a blood pressure of 96/50 and a systolic and diastolic murmur. Patient was weak, unable to walk and complained of severe headaches. He had a coarse tremor of the upper extremities and a positive Romberg. There were no other essential, pathological, physical findings. No acne was present. The deep tendon reflexes in all extremities were symmetric and within physiological limits, as were the abdominal and cremasteric reflexes. No Babinski sign was present. The eye grounds failed to reveal essential pathology. The urine was negative. The blood count showed 4,200,000, RBC; 85% Hgb.; 6,000 WBC, with a normal differential. The blood urea was 16 mg. % and a fasting blood sugar 107 mg. %. X-rays of the chest and skull were negative, as was the blood Wassermann. The spinal fluid showed 2 cells, a negative Wassermann and a flat gold curve. A bromide level showed it was 320 mg. %.

The mental examination on this patient revealed a pale, undernourished patient, unable to walk, disorientated for time, place and person, who expressed auditory and some visual hallucinations. He heard and saw members of his family around; he had numerous delusions, the ones that somebody was going to kill him; others that the trailer in which he lived had burned down and also that he had stomach ulcers which were going to turn into cancer. Patient was unable to form logical concepts and his answers to questions were mostly inappropriate. There was a considerable flight of ideas and he showed some depression, or rather preoccupation, about his impending death. He was not antagonistic or hostile and tried to cooperate with the hospital staff to the best of his ability.

A psychological and psychometric test (Wechsler-Bellevue, Rorschach, and TAT) showed a low, central I. Q. of 83, with the highest score 125; high average in reality and a tense and insecure individual who could function fairly well in not too stressful conditions but tended to avoid situations which taxed his emotions too much, because he feared not to be able to handle them.

Patient is the youngest of three children. He had little schooling and could scarcely read and write. He had had numerous odd jobs but his vocational progress was impaired by heavy drinking. Patient is single. There is a history of having been engaged to a girl long ago but she had left him because he would not stop drinking. 5-6 months before his admission, he worked as a gardener in an institution and liked his job. He stopped drinking, fearing he would lose this job again. To control a feeling of discomfort and vague gastric pains, he started to take Nervine which contains about 600 mg. of different bromides in 4 cc. He took about 6-8 teaspoonsful of this medicine daily. Later he decreased the Nervine and started to take

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Bromo-Seltzer, which contains 320 mg. sodium bromide and 160 mg. acetanilid per teaspoonful. He took about two teaspoonsful, q.i.d.

Patient was put on salt-glucose tablets and on high doses of vitamins. The bromide level decreased gradually from 320 mg. % on 11/7/52 to 160 mg. % on 12/2/52, and 20 mg. % on 2/12/53.

His physical and mental condition improved more or less proportionally with the decrease of the bromide level in the blood. With 210 mg. %, he could already walk with some support but was still delusional. With 180 mg. % he realized that his trailer was not burned, and with 160 mg., he realized that he had been sick and "out of his mind." He attended group therapy sessions for alcoholics, worked in the ground crew, and was discharged January 24, 1953. His diagnosis was acute brain syndrome, associated with drug intoxication (bromides).

COMMENT

Reynolds and Ware[2] describe several cases of intoxication due to Bromo-Seltzer, where the symptoms, mostly persistent cyanosis, are due not to the bromides in the Bromo-Seltzer but rather to the acetanilid, which does not form, as believed previously, methemoglobin in the blood, but sulfhemoglobin. It is not impossible that the condition in patient which was diagnosed as myocarditis and pneumonitis may have been due to acetanilid intoxication.

Levin[3] describes in his paper, four types of bromide poisoning. The two first, more common, are (1) simple bromide intoxication with dullness and sluggishness but with unimpaired orientation and no delusions or hallucinations; (2) the delirious type with severely impaired orientation in all three spheres, fears, restlessness, impairment of the thinking process and delusions and hallucinations. He describes further two less common types, (3) bromide hallucinosis and (4) bromide schizophrenia. The orientation is unimpaired and hallucinations occur in both. In bromide hallucinosis they are, however, rather threatening to somebody else and the afflicted patient experiences them only as a horrified spectator. In bromide schizophrenia, the hallucinations are more personal and threatening to the individual. This type is difficult to distinguish from a schizophrenic reaction, except that it starts only with a certain bromide level and recedes when the level decreases. According to this classification, the patient here presented would have suffered from Type 2. Though his premorbid personality has not shown a too good adjustment (he was single, drinking, and had a poor work record), it does not seem that it had a special influence on his symptoms, since they were of a type described rather frequently.

SUMMARY

The case of a 41-year-old man is presented who showed psychotic symptoms after consumption of large amounts of Nervine and Bromo-Seltzer for several months, after he had given up alcohol. The possibility that an acute disease, one week before his admission to Delaware State Hospital, which was diagnosed as myocarditis, could have been due to the acetanilid contained in Bromo-Seltzer is discussed. The danger that drug addicts may switch to easily available bromides when barbiturates become more difficult to obtain, is pointed out.

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NON-CONVULSIVE SHOCK THERAPY
With The Reiter Electro Stimulator

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This is a report of six patients who received electric shock treatment with the Reiter Electro Stimulator for varying periods of time. Many papers have been written describing the results of experience with this Stimulator and other forms of non-convulsive therapy. It is the purpose of this paper to discuss some experiences at Delaware State Hospital with this form of treatment.

Case 1. This patient came to the hospital with a diagnosis of psycho-neurosis, obses-

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sive compulsive type. She received 20 treatments with the Reiter Electro Stimulator. Following these treatments, the patient improved and was able to return to her home.

Case 2. This was a patient with a diagnosis of chronic brain syndrome due to cerebral arteriosclerosis. She received 20 treatments with the Reiter Electro Stimulator and improved and went home.

Case 3. This was a patient with a diagnosis of involutional psychotic reaction, paranoid type. She received 20 treatments and showed only very slight improvement. This improvement lasted only a few days, however, and the treatment was considered a failure.

Case 4. This was a patient with a diagnosis of manic depressive psychosis, depressed type. This patient, on previous hospitalizations, had received regular convulsive shock therapy and had improved enough to return home. She was given 22 treatments of the non-convulsive type with the Reiter machine. She showed no improvement. Following those treatments she was given regular convulsive shock treatment. She then showed improvement.

Case 5. This was a patient with a diagnosis of schizophrenia, catatonic type. This patient had previously received regular convulsive treatment and had improved. She was given 1 treatment with the Reiter Electro Stimulator of the non-convulsive type. She became more bewildered and catatonic than she had been previously and treatment was discontinued.

Case 6. This was a patient with a diagnosis of paranoid condition. She received 3 treatments of the non-convulsive type and showed no improvement. Later, she was given treatments of the regular convulsive type and improved enough to be returned to her home.

We see here out of six patients two who improved and were able to return home, which is a total of one-third of the patients who improved. Two patients who received treatment and who showed no improvement were subsequently given regular convulsive shock therapy and showed marked improvement. One patient receiving only non-convulsive treatment showed very slight improvement and immediately slipped back. The last patient became worse.

Our experience with the non-convulsive therapy has been rather discouraging. We find that there are some instances in which convulsive forms of shock therapy are impractical. These cases include those with abnormalities of the spinal column and also those who are very elderly or debilitated. In those cases we still find that the non-convulsive form of therapy is worth trying. Because of the better results obtained with the convulsive form of therapy, however, as well as the ease with which the regular therapy can be given, in most instances we find that it is better and more convenient to use the regular convulsive form of therapy. One disadvantage in using the non-convulsive form of therapy is that it requires more personnel and time, since the patients must be anesthesised with Pentothal.

TABLE I

CASE	RESULT
1	Improved
2	Improved
3	No change
4	No change*
5	No change*
6	Got worse

*These patients were later given regular convulsive therapy and improved.

TABLE II

Improved	33%
No Change	50%
Got Worse	17%

CONCLUSION

Our experiences indicate that the use of non-convulsive electric therapy is disappointing compared with regular electroshock therapy which seems to be more practical in technique and more effective with regard to outcome.

ON REGRESSION

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The word regression, as a psychiatric term, connotes going back to early thinking processes that perhaps are long forgotten by the people concerned. At times

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these processes originally date so far back that these manifestations seem thoroughly new, or peculiar, to others and even strange to the very person manifesting them. Regression may take many forms, usually childhood experiences previously deeply impressed in the young mind, old habits or gestures that have been reassuring during threatening moments in the past, or, they may be a reactment of a reaction to a traumatic episode which has been pushed back in the subconscious and repressed. To regard regression, however, as a deteriorating or deteriorated process is not only erroneous but itself increases the stress on the person suffering because more efforts are required of him to overcome what is regarded as a state of deterioration adding insult to injury, as it were. Yet, we find this a very popular conception among therapists.

Clinically, signs of regression are usually observed in cases of withdrawal such as seen in schizophrenia. We also see them in involutional cases. For this reason the impression of deterioration and hopelessness was suggested in the manner of old people being unable to become young again to do the things they wanted to do in life. Perhaps this very fact ought to make us wonder whether efforts of the so-called senile cases not to be treated as handicapped by age get them to act like little children and set up such a pattern of conduct and behavior. This shows very clearly in one way how culture affects individuals and how individuals think and act in the effort to get along in the environment. We are all familiar with the more tolerant and condescending attitude of people towards elderly individuals similar to that found in our attitude toward children and helpless animals in general. While the latter group unknowingly live through this period, elderly people can utilize the opportunity to turn the tide of being taken casually, and, for granted by actually getting themselves looked after when they manifest what is called signs of regression. There is no question that age limits individual capacities to certain points but there is no basis that this should be a handicap as it is presently conceived and still accepted. Current studies on geriatrics disprove crippling by age per se, and, those that are, have chronic diseases which otherwise could have been attended to prior to advanced age. More and more we come across people in their eighties, and above, who are well integrated and profitably occupied. They provide data which disclose that people in the old age group experience normal desires and impulses and preserve their attributes. We certainly defeat our purpose of prolonging life were we to close our eyes to the utility of same.

Going back to regression, I would like to present it as a flashback of the mind where old scenes are reproduced and acted out by a person who is undergoing a need to do so. Such a person is working out, or, trying to work out a particular situation called for at the time necessitating the manifested symptoms. He is forced to use old techniques because the present conditions have apparently exhausted other resources. It is also possible that the person himself is exhausted psychically so that things have gotten out of control and he is pushed back to old patterns like the prodigal tracing his footsteps home because he failed to find his way out in the world.

By studying and, therefore, learning what the person is trying to say and do by what we call regression and by taking these things up with him in therapy, we can help in clearing up the psychological kinks in his mind where he is caught up in snags and unable to communicate otherwise. Since such a condition involves the most important things in life for this person, he will not give up working on his dilemma even when all therapists do. This fact points to the neurotic personality involved but we all manifest varying degrees of neurosis in the neurotic wear and tear of everyday living. If we keep this in mind, we will be perhaps more successful in following the thinking processes of these patients.

+ Editorials +

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Hope For The Future In Delaware Mental Health

The geographical position of the state of Delaware is one of strategic value. As a "border state," Delaware has been asked to participate in the Southern Governors' Conference and in the Conference of Northeastern States. The association of Delaware with these two groups of states at this time is of particular advantage to those interested in improving and expanding the resources on the state for training psychiatric personnel and in developing research in mental health. Both of these conferences are directing much thought and effort toward preventing mental disorders in persons with potential for such breakdown and toward discovering ways of more effective treatment and more rapid rehabilitation of already mentally ill persons. The states of the Southern Region especially have taken action which gives hope for greater advancement in this area, viz. a study of their own resources for training and research in mental health, and consideration of ways in which the resource of one state may be made available to another state lacking such facilities.

Delaware has much to contribute to the other southern states. The resources for research in this state are limitless if industry, medicine, and other groups will join with mental health personnel in seeking solutions to these problems.

Since research is dependent on the availability of well-trained personnel, the state of Delaware should give serious thought to making available to its young citizens the opportunity of obtaining a medical education at home. Just as some of the other scientific departments at the University of Delaware have been expanded to provide specialized education, a school of medicine could be developed there.

It is hoped that the Governor will comply with the request, which has been made previously, to appoint a committee to explore the need for a medical school at the State University, and if such a need is revealed, to seek the means through which the state, with the help of interested individuals, can establish such a school. This school would be basic to the training of psychiatric personnel and permit state citizens to make fuller use of residency programs already approved at institutions in Delaware.

CHEST X-RAY SURVEY

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In December, 1953, a mobile chest x-ray unit of the Delaware State-Wide Chest X-ray Survey visited the hospital and x-rayed patients and employees on 70 mm. films.

There were 961 patients and 219 employees who received this service, a total of 1180 chest films. Patients who were physically or mentally unable to have a satisfactory film taken were not done.

The large number of employees (214) who were not x-rayed at the hospital availed themselves of this Survey service in their local community in practically every instance.

Following this service the films were read by a member of the Survey and who reported that there appeared to be abnormal findings of 80 of the patients and personnel on viewing this total of 1180 films.

These 80 cases are listed in Table 1. You will note that the patients and personnel have been separated and also the percentages are included. Besides the following tabulation, there were reported four abnormal heart shadows, three of which were dextrocardiacs and one enlargement in size and shape of the shadow.

TABLE 1

	Patients		Employees	
	No.	Per Cent	No.	Per Cent
Tuberculosis				
Minimal	27	2.8	3	1.4
Moderately advanced	8	0.8	1	0.5
Far advanced	3	0.3	0	
Calcium pleural plaque	2	0.2	1	0.5
Infiltration of bases	6	0.5	1	0.5
Diaphragmatic hernias	7	0.7	0	
Calcified nodules	10	1.04	2	0.91
Tumor mediastineum	2	0.2	0	
Bronchiectasis	2	0.2	1	0.5
Intrathoracic goiter	1	0.1	0	
Pneumoperitoneum	1	0.1	0	
Bulbous emphysema	1	0.1	0	
Pericardial cyst	1	0.1	0	
	71		9	

The abnormal findings, except the heart shadow report, were to be followed up on 14x17 cm. chest films.

This follow-up is listed on Table 2. Again the patients and personnel have been separated and the percentages included.

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TABLE 2

Recheck	Patients		Employees	
	No.	Per Cent	No.	Per Cent
Tuberculosis				
Active				
Moderately advanced	5	0.52	1	0.46
Inactive				
Minimal	18	1.88	3	0.91
Moderately advanced	3	0.3		
Calcium deposits	6	0.62	1	0.46
Calcified plaque	1	0.1		
Bronchiectasis	2	0.21	1	0.46
Emphysema	1	0.1		
Thickened pleura	2	0.21		
Elevated diaphragm	1	0.1		
Passive congestion	2	0.21		
Pneumonary abscess	2	0.21		
Enlarged heart shadow	3	0.3		
Not obtainable for x-ray	1	0.1	1	0.46
Negative	24	30.0	1	1.25
Rib resection			1	0.46
	71		9	

The above readings of the 14x17 cms. films were by the consulting roentgenologist.

Three of the presumable active cases were known prior to the Survey, as were the majority of the inactive cases. The one active case among the personnel went to the sanatorium for treatment. The remaining five had gastric washings which were negative for acid fast organisms. Serial x-ray films have shown either retrogressing or stationary lesions; in none of the cases has there been any progression.

The tuberculosis figures appear lower than reported from some other mental institutions. It is not felt that the patients and personnel who were not x-rayed would materially alter the percentages.

These lower morbidity totals may be somewhat due to the fact that all patients on admission receive a chest x-ray film, while all applicants for employment receive a physical examination including a chest x-ray or a fluoroscopic examination.

The present trend toward providing treatment and supervision in the home for a relatively longer period of the tuberculosis patient's illness is creating some important problems. It makes close coordination among all professional personnel involved—physicians, nurses, social workers, rehabilitation workers, and others—even more important than before. James E. Perkins, M. D., NTA Bulletin, May, 1954.

THE PSYCHOLOGICAL MEANING OF ENURESIS IN MALES

A Working Hypothesis

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For the purposes of this study enuresis is defined as an involuntary, repeated micturition after the age of three. Enuresis should be distinguished from urinary incontinence which is considered to be directly due to gross organic pathology.[4,9] Estimates of the frequency of enuresis in children vary from 1% to about 25% of the population in pediatric out-patient clinics.[9] Powell[8] estimates that 15% of all children are enuretic.

Enuresis is regarded by many as an indicator of emotional disturbance.[1,2,6,8] As with any other neurotic symptom it is extremely difficult to assign a specific meaning to the symptom. The same symptom may have a multiplicity of causes. Studies with children and adults[1,2,3] have pointed consistently, however, to the fact that the parent-child relationship is of the utmost importance in the development of enuresis. It is the author's thesis that enuresis in males is determined by two major factors. On the one hand, enuresis is a symbolic expression, at a behavioral level, of hostility experienced at an unconscious level toward the mother, when such hostility is not permitted conscious expression. Enuresis also represents a reassurance against castration fears, also at an unconscious level.

The following discussion is based on an analysis of 7 cases of enuresis in males ranging in age from 6 to 14. The cases were seen at the Delaware State Mental Hygiene Clinic during the six month period ending in May, 1954. The Clinic examination consisted of a psychological evaluation, a psychiatric evaluation and a social service investigation. The psychological evaluation consisted of an intelligence test, Rorschach Test, Human Figure Drawings, and, in two cases, the TAT. Because of the limited nature of the sample, the results are presented as tentative. The possibility of other factors underlying enuresis cannot be ruled out at this time. The specific modifications necessary to explain enuretic behavior in females has not as yet been worked out.

In terms of personality configurations each of the 7 enuretic males was described by the psychologist as passive and overdependent, with difficulty in expressing hostility or aggressive feelings overtly, particularly as related to the female. In each case the female, (mother figure) was perceived as essentially threatening, and identification was with a weak, ineffectual father figure.

Case history and clinical material round out the picture of inter-family dynamics. The mother was the dominant member of the family and the patient's relationship with his mother was characterized by excessive overdependence and passivity. This passivity tended to generalize to all the patient's relations with authority figures.

The psychological dynamics leading to enuresis may be theorized as follows. Hostility is experienced toward the mother because of her aggressive, domineering over-protectiveness. Because of the child's unconscious perception of the mother as threatening, and the fear this engenders, this hostility cannot be expressed at a conscious level. The child is therefore passive in his relationship with his mother. He has not made a strong male identification because of the weak ineffectual father and therefore has none of the "masculine" aggressive releases available. The child's security as an individual and his supply of comfort and nourishment is threatened if he expresses the hostility he feels. "If I tell Mommy I hate her, she won't love me anymore; she won't take care of me anymore." Carrying the analysis one step further, if this hostility is expressed directly the child feels that retaliatory action will be taken by the mother. At the unconscious level this retaliatory action is castration. Enuresis thus may be viewed as a reassurance that this castration has not taken place.

Perhaps the most common apparent contradition to this theoretical explanation is

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the child who develops enuresis seemingly as a result of an operation or some other traumatic event. It is the author's contention that in such cases the psychological conditions described above exist in the home but are not intense enough to produce enuresis. The traumatic event is necessary to trigger the symptom. Enuresis will begin in such cases if the child interprets the traumatic event as essentially castrating in nature.

Enuresis viewed in this way has a two-fold meaning. On the one hand it is an expression of hostility toward the mother. It also represents an unconscious reassurance against castration.

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SOME REACTIONS Of Emotionally Disturbed Children To Academic Retardation

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The children who are in residence at the Governor Bacon Health Center because of emotional difficulties tend on the whole to be retarded in their school learning and to be working below the intellectual level indicated by the WISC or other standard measure of general intelligence. The median IQ of our population is in the low average category, but at least 35 per cent of the children are average or better in IQ. Computation of the Jastak altitude,[1] other analyses of WISC performance, interpretation of Rorschach protocols, and general behavioral clues often suggest that potentially many of these children can perform at an even higher level. Their social and emotional deprivations are probably reflected in their present level of general functioning, and they affect even more greatly their academic accomplishments. The children are not unaffected by this retardation; for many of them, it is a self-percept which further lowers their sense of self-worth and adequacy and which further contributes to any guilt feelings which they already have about past misdemeanors and other failures to cope with their life situation. The present writer, in her experiences as psychologist at Governor Bacon Health Center has been impressed by (a) the extent to which many of these children are deeply concerned with their apparent learning difficulties, and (b) the degree to which this worry is revealed by or reflected in the routine testing of school achievement.

The first point is perhaps illustrated by a brief account of a child with whom the writer has had a therapeutic relationship in which such worries have been extensively aired.* Martin came to the Center at the age of seven with a record for wandering late at night, ransacking cars, and breaking and entering. He is the second oldest of seven siblings and half siblings; his father had deserted the family some time earlier, and his mother was finding it difficult, even with financial aid from the community, to maintain an adequate home. Psychological testing indicated Martin's general intelligence to be at least average, but school achievement virtually non-existent. Nor was much learning accomplished during Martin's first winter here. On admission he seemed to be poorly related to adult authority and at times he became extremely defiant. He kicked. screamed and had prolonged temper tantrums. He was beset by bad dreams and even night terrors. Psychiatric evaluation suggested that he was harrassed by many fantasies and fears centering around Oedipal conflicts. This was confirmed by his behavior during therapy. These conflicts cannot be discussed at length in the present paper, but one aspect of the situation seems to be that he has felt a deep

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1 Jastak, Joseph; A Rigorous Criterion of Feeblemindedness, J. Abn. (Soc.) Psychol. 44; 367-379, 1949.

*All psychotherapy at the Center is under the supervision of the Child Psychiatrist.

sense of responsibility for the welfare of his mother and young siblings and has attempted in irrational and inadequate ways to be adult and to live up to his responsibilities. In the face of his inability to alleviate the home situation, he collapsed and regressed to primitive tantrums and other infantile behavior. During residence at the Center the general milieu effected some gradual improvement in Martin's adjustment. When he began to be seen in individual therapy about a year ago he made initially rapid strides in working through some of these problems and in examining and overcoming some of his fears. In a short time there were further noticeable changes in his everyday behavior. This surface adjustment has continued, and there has been further deeper but less dramatic progress, which is not so directly reflected in his cottage and school behavior. During his months in therapy, however, there have been two serious setbacks, two periods in which he reverted to the disturbed, uncontrolled, infantile behavior patterns which he showed on admission. One of these followed a Thanksgiving visit home in which he discovered his family living in a very inadequate apartment, with no heat or light, and with broken windows stuffed with newspaper in an unsuccessful attempt to keep out the bitter November wind and snow. His mother and the two youngest babies were ill. The other period was an earlier one in which he started back to school in September.

Martin is a child who is able to express his feelings verbally as well as indirectly through play activity, and it has been very clear that the two incidents were not unrelated. Both collapses were precipitated by his very deep sense of failure and inadequacy. In the first case he was overwhelmed by his family's plight. Night terrors returned, and he "went to pieces" frequently in the daytime. He tore off his jacket and even his shirt and pants and tried to run outdoors in his underwear. If placed in seclusion he tried desperately to share his mother's discomfort by attempting frantically to turn off the radiator and to claw holes in the wall. At one point he tried to run away to join his family, and he dictated the following note to each of several staff members at the Center in an endeavor to explain to them his erratic behavior and his desperate need to help provide warmer and more adequate quarters for his family:

> "I'm running away and going out the gates, going to Delaware City. After I get done with Delaware City I'll go to a little cabin and first I'll have to get some matches and light a fire and go get some wood and light the fire brighter and then I'll come back to the Center and hide."

The earlier relapse was equally a time of extreme disturbance in behavior for Martin, marked mostly by an inability to tolerate school, by an increase in his expressed fears of devils, ghosts, and other threatening figures, and by frequent tantrums. It was difficult for this youngster to accept the confinements of a structured classroom after experiencing the greater freedom of the summer program at the Center. It seemed to be not these pressures however, which bothered Martin so severely; it was rather his sudden, acute realization that he was spending his time literally in the same classroom as he had the year before, that, although his arithmetic was fair, he could barely print his own name, and that he was nowhere nearly ready for the third grade work which he felt that he must accomplish. It was a stormy time for him until he was finally able to reconcile himself partially to his retardation and to try to begin his learning at the level of which he was then capable. Again he seems to have felt an overwhelming obligation to play an adult role in his family and an acute sense of his inability to do so, which almost prevented him from functioning effectively at any level.

Another way in which these children's underlying concern over their school progress manifests itself is during the psychological examination of the youngsters.* In general, the task of psychologi-

*All children at the Center are tested by the psychologist from time to time. Tests used routinely are individual intelligence tests, school achievement tests, and various projective techniques appropriate for children. They also include on occasion special techniques such as those for exploring the possibility of organic damage in certain youngsters, those for assessing vocational choices and aptitudes of teenagers, and so on. There is also the opportunity for informal interviews, free and controlled play, as well as observations of the child's actual behavior in the classroom, on the playground, and in the cottage, and we find that such information can be very valuable as an adjunct to formal testing.

cal evaluation in a residential treatment center is a somewhat different matter from that in an out-patient setting, and in general, the task is somewhat easier. There is the advantage of having first-hand informal observations against which to check the more objective and formally derived test quotients. It is also possible to choose a time when the child seems not too upset emotionally to apply his best efforts, to set the pace of the testing to the child's needs, and even to cancel and reschedule appointments if this seems advisable. A further interesting aspect of testing in such a setting is the fact that the psychologist is inevitably in the child's eyes an integral part of a larger setting in which the youngster is living his daily life, and this means that the child brings some of his attitudes toward the milieu into the testing situation.

On the whole this imbedding of the test situation in the total treatment setting is an aid to testing. The children, by and large, have comfortable, positive feeling toward their environment which they perceive as sympathetic, permissive, and non-threatening, and it is indeed this very atsmosphere which the examiner wishes to establish in the test situation. Occasionally however, this relaxed feeling would seem to lead to difficulties in eliciting the child's full cooperation and effort; this is particularly true in the administration of seemingly routine proficiency tests such as the Wide Range Achievement test (WRAT)[2], which explores the three basic school subjects of reading (word recognition), spelling, and arithmetic. This test is routinely given at the time of admission*, and at regular intervals during the child's subsequent stay at the Center. It is easy to administer and score, and it is useful in understanding the child's total adjustment as well as of specific value in deciding school placement at the Center or in the community after discharge. It is a test, however, which seems to be emotionally charged for many of our children, perhaps because of the very fact that it is a completely straightforward and undisguised challenge to them.

Some few children refuse flatly to undertake the test at all, or only extensive persuasion, reassurance, and encouragement induces them to do so. Some invent elaborate reasons for postponing the session. Others begin the test but soon become obviously agitated when they reach unknown words or baffling problems and may need to leave the room for a while and come back. With a little help, many of them verbalize their discouragement and embarrassment very freely. Still others try in very transparent ways to disguise or deny their retardation by magnifying it to an absurd degree so that their actual level of achievement will be obscured. Allen is a bright 13 year old who is an accomplished reader, but somewhat retarded in spelling and poor in fundamentals of arithmetic. On the test he read without hesitation, but began to misspell words deliberately, and when he came to arithmetic he soon began very openly and deliberately to falsify his answers. Frank, another 13 year old of normal intelligence, who is performing on an inferior level in all three areas, was relatively cooperative in arithmetic (his best subject), but balky on other parts of the test. Several times he stated despondently, "You may *think* I know it, but you can't *prove* it." He even read the words "cat, milk, red, tree . . . . city" as "dog, water, green, bush . . . country." He also misspelled his own name and filled in his age as 3 and his grade as 1. In his case it was of course easy for the examiner to detect his "malingering" and to discuss it with him before proceeding to obtain a more valid estimate of his present proficiency. In other cases, children's failures to put forth effort are less conspicuous, but the examiner must be alert for more subtle signs and must be able to reassure and reconvince the child that he is accepted as he is, that there are still opportunities for him to progress,

[2]Jastak, Joseph: Wide Range Achievement Test, Wilmington: Chas. L. Story Company, 1946.

*Many of the children have recently been tested at Mental Hygiene Clinic or in the school system. If so, results are available and testing is not duplicated.

and so on, before the child is able to reveal his actual level of achievement.

It is the writer's impression that such difficulty in obtaining valid performances in achievement areas is most frequently encountered with children for whom there is a marked discrepancy between general ability and actual school progress. That is, it exists with children who are noticeably retarded academically but who are average or better than average in general intelligence and are therefore perceptive enough to realize all too clearly their inferior academic status. Furthermore, it would seem that it is children who have been in residence for some time who reveal most strikingly their agitation and concern. Newly admitted youngsters, with a minimum of effort on the examiner's part, seem to conform to the demands of the testing situation and to give a straightforward performance, albeit unhappily in some cases. Older residents, however, may be already acquainted with the examiner as a participant in their daily lives or may simply regard the psychologist as part of a total setting, a setting in which they have come to feel at least partially comfortable. The result is that while some of these children may thereby feel relaxed enough to take the test in a matter-of-fact way, others react by feeling free to reveal not their actual accomplishments but their dissatisfaction with themselves and this they act out in some of the ways described above. They therefore require rather special effort on the part of the examiner, a fact which makes even the administration of routine tests a difficult but interesting experience for the psychologist in a residential treatment center.

FAMILY CARE

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Mary A. was 17 when she was committed to a State Hospital for treatment of a schizophrenic reaction with predominating hebephrenic features. At first she showed apparently good response to treatment, but the improvement proved to be superficial and eventually most of the somatic treatments were used. The initial insulin treatment was followed by electroshock, and later a prefrontal lobotomy was done.

It was realized early that planning for her to leave the hospital would present some special difficulties. Both parents were dead, an older sister was married and living several hundred miles away, both brothers were in the Army at the time of Mary's admission, although the older was soon discharged and started his professional training at a near-by university. It was not felt that a foster placement through one of the children's agencies would be satisfactory. Mary's guardian, together with a brother, found a home for her with friends of the parents and a trial visit was arranged after the re-training period subsequent to the lobotomy. This home had some limitations and Mary's poor adjustment there was supported by the interference of the brother who was extremely protective of her. When she returned to the hospital the staff was particularly concerned about her attitude of "coming back home" and her wish to remain at the hospital indefinitely.

During this period the State Legislature, at the request of the Division of Mental Hygiene, had approved organization of a Family Care Program and funds had been allocated for this purpose. Some patients were already placed, but none of the homes then in use was found suitable for Mary, and several others were studied. The one that was selected by the Social Service Department was a farm home near a small college town; the foster family was acquainted with another state hospital through previous employment there; in the home was another girl of Mary's age who also had her high school work interrupted, because of neurological difficulties, the high school in the district was a good one, and it was felt that the town offered social resources for both girls. The essential difference between the earlier trial visit and this placement was that this home had been selected by the hos-

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pital and both the home and the patient would be closely supervised by the hospital. The placement was discussed fully with her brother, plans were made for his visits to his sister and he was encouraged to bring any criticism to the social worker, instead of to the foster family directly.

Mary went to the Family Care home during the summer and was well adjusted there before school time. In September both girls returned to high school to complete their last two years. She also became acquainted with some of the college students, her own family visited from time to time and, during holiday times, she visited their homes; the hospital social worker visited frequently and she was seen less frequently by a psychiatrist at the hospital. Three years later she was no longer under hospital supervision, but did see the social worker from time to time at her own request. Not only had she finished high school, but she had completed one year at the state University and was planning to return there, and had summer employment. There has been no recurrence of her illness.

Family Care is the placement of patients with families other than their own for continued care and treatment. This may be because the patient has no near relatives, or because the homes of near relatives are not suitable for the needs of the patient. In general, this placement is used for two types of patients: (1) those who may be chronically ill but who have adjusted at a comfortable level, and who will be happier in a family home rather than in an institution; and (2) those patients who need a period of convalescent care before returning to their places in the community. Family Care placement may be used to bridge the gap between the Hospital and the home environment, or it may take the place of the home environment which is no longer available. It is individual placement with an individual family and is not to be confused with placement of a patient with a group in a different institution or nursing home.

The Group for the Advancement of Psychiatry (G. A. P.) states: "The responsibility for selection of patients and their medical supervision while under such care belongs entirely to the psychiatrist. The responsibility for finding a suitable home, for interpreting the patient and his needs to the foster family, for maintaining proper standards of care, and for helping the patient in his social readjustment, is primarily a function of the Social Worker. There is no other professional group qualified by training and experience to assume this responsibility."

Historically, Family Care originated in Gheel, Belgium, the site of the death of Dymphna, Irish princess and patron saint of the mentally ill. Many ill persons visited the town and, as there was no hospital there, were cared for in private homes. In 1852 Belgium recognized that a practical plan for the care of certain types of mental illness had developed and the program became part of the country's mental health planning. Scotland adopted the plan in 1857, and France, Germany and Switzerland soon followed. Our first state to establish the program was Massachusetts in 1885, New York and Maryland were next in 1935, and now many other states are using the plan.

The most important objective of Family Care is, of course, patient therapy. However, in places where the program is in operation there are interesting and stimulating community reactions. The community is drawn closer to the hospital, misconceptions about "insanity" are dispelled, and a healthier attitude toward mental illness and maladjustment has resulted.

Practically there are other advantages, too. Placement of a patient in a Family Care home releases a bed for an acutely ill patient in the hospital; placement of a number of patients may slow down the need for capital expenditures; the cost of

this type of care is less than the cost of care in the hospital.

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THE REJECTED CHILD
The Social Worker's Approach To The Problem

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The rejected child is usually pictured as a forlorn, unhappy, unwanted youngster, whose parents have abandoned or seriously neglected him. There are such children and the state has provided for their care by the Department of Public Welfare. This Agency secures the best possible substitute for the warmth and security every child has the right to expect from his own mother.

This paper deals with the less obvious rejection from which many children suffer. The mother is seldom aware of this feeling within herself; the child, with his keen sensitivity to his emotional surroundings, may know something is very wrong in his mother's feeling toward him and reacts in such a manner that behavior problems are soon apparent. This aggressive behavior brings forth more such rejection with its concomitant guilt, then further aggressive behavior on the part of the child who is feeling pretty guilty too, about his hostility toward the person who means more to him at his early age, than any other.

The primary difficulty lies not in the rejection itself, for everyone rejects and is rejected again and again. Pure unmitigated love exists only for the romanticist. Love and no-love, or to use a stronger word, hate, exist together, in every human relationship.

The real problem stems from guilt that may be engendered by the rejection; guilt pushed down out of sight and out of mind, but rising again in another form—an overwhelming need to deny the rejection by being over-solicitous. Friends of this mother say admiringly, "She certainly is a good conscientious mother," and perhaps after a time they will add "—but that child can't move without her hovering over him." The teacher sees her walking the boy to school so he will be safe from such hazards as automobiles and bad boys.

The doctor sees this mother in his office very frequently; "Johnny just won't eat the food he needs. I try so hard to get him to eat. Won't you give him a tonic?" Johnny learns that when he complains of illness he gets a good deal of solicitous attention so; "Oh, Doctor, I'm so worried about him, he just doesn't seem well. Do you think there is something seriously wrong with him?" Sometimes the child's aggressive behavior is the main complaint. Often the physician sees this behavior as the most obvious problem. To quote one doctor, "He practically tore my office apart when the mother brought him in."

The physician, the minister, or the school will hopefully refer this child to the Mental Hygiene Clinic before the situation is too far out of hand, for here the mother too will get whatever help she needs and is able to use. If the physician or other referring person recognizes the problem as one of relationship and can himself feel comfortable about the services offered by the Mental Health Hygiene Clinic to mother and child, he can prepare the mother to expect real help, as he refers her to the Clinic.

The social worker has the first contact with this anxious over-solicitous mother and is trained in seeking out the underlying causes for the mother's feelings. Was the baby a boy, when the mother had set her heart on having a girl? Did the advent of the baby interfere with the social life of the young parents? Was the child born out of wedlock or perhaps too soon the first year of marriage? The social worker seeks the answers to these and many other questions as the mother pours

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out her story of her problem, and her deep concern over it.

Supported by the understanding attitude of the social worker, the mother is very likely to bring out what has probably been obvious to the physician or other referring source; "Maybe it's my fault. Maybe I'm the one who needs help." The social worker lets her know that help is available; reassures her that she is not a "bad mother" when she becomes completely exasperated with her child, nor even when the youngster says to her "I hate you." All mothers are exasperated at times; all children hate when their wants or activities are thwarted. The social worker points out that mothers and children love each other too. She gives the mother an opportunity to pour out her pent up feelings and anxieties.

It is not unusual to learn later that this first interview between mother and social worker has been of sound therapeutic value, with tensions between mother and child eased even before the child is seen in the Clinic for psychological tests and psychiatric evaluation. In addition, the ground work has been laid for the recommendations of the Clinic staff as to treatment of the problem. The child may need only a few sessions of play therapy, in a permissive setting, as offered at the Clinic, while the real work is done with the mother. The services of the psychiatrist or social worker are available to the mother, depending on the seriousness of her problem.

Love is both an individual phenomenon and one common to all mankind. Most parents put their very best conscious effort into the relationship with their children and feel hurt, frustrated and completely at a loss when this effort is not rewarded by the love and confidence of their children. They are then so close to the problem and so emotionally involved as to need the help of an understanding professional person.

A CASE STUDY
When A Child Leaves A Residential Setting

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Perhaps one of the most vital aspects of treatment of a child is his preparation for eventual discharge from institutional care. It is at this time that the child is first presented with the prospect of leaving a protected therapeutic relationship to enter into the midst of a questionable and often times threatening new environment.

It shall be the purpose of this paper to describe by way of a case presentation some problems involved in such a procedure and the caseworker's responsibility in dealing with them. Special emphasis will be placed on the caseworker's responsibility in understanding the child and preparing the family, as well as school and social agencies for the patient's return to community living.

Up until six months ago, and for a total period of two years, Jimmy, a 15 year old negro youngster, had been a patient at the Governor Bacon Health Center. He was referred originally by Family Court because of uncontrolled behavior in the community and violation of curfew. He had run away from his foster parents (both his parents had died by the time he was age 10) on several occasions, lied and stole. When apprehended, he gave false identifications; stating he would run away again if forced to return. It was the feeling of the court that he needed residential treatment and he was admitted to the Center. Furthermore, such a placement would allow the authorities responsible for the youngster, to thoughtfully consider and plan for future home placement for him.

At the initial psychiatric staff presentation it was determined that much of his behavior seemed a reaction to his feelings of rejection by his foster parents. Even at this time he expressed his desire to grow up and be self sustaining because

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he had not felt that he could depend on the adults in his past. He showed disorganization of personality, flattening of affect and a predominant mood of sadness, resentment and discouragement. His verbalization was poor. Psychological tests showed him to have average capacity with an ability to concentrate in a purposeful, persistent manner. He performed adequately on tests requiring visual motor coordination, but poorly when analytic, synthetic skills were required. There were no positive physical findings. He was diagnosed as: social problem, primary behavior disorder, personality disorder (excessive introspection, masochism, schizoid traits), conduct disturbance, truancy, stealing.

His prognosis was considered fair with treatment in a psychotherapeutic environment. Reevaluation of the foster parents' attitudes was considered essential.

Jimmy's school and cottage adjustment at the Center varied from fair to poor during the early months of his stay. At school he appeared out of touch with reality, bullied other children and seemed to enjoy being beaten by those his size or larger. His bigness in the group led him to increased bullying, sensitivity and craftiness. Academically he maintained a fourth grade level but on a verbal basis was roughly two full grades higher. At cottage he was immediately labeled "crazy" by the other children because of his fantastic tales. His story telling was frequent and it was difficult to obtain factual data from him. This habit decreased gradually, and he improved in many ways, especially in personal appearance and group relationships. Jimmy was observed to stutter often, to bite his nails and pick his clothing. He also showed evidence of having many fears.

Jimmy's caseworker had interviews with him during his first year here on an infrequent basis. Several contacts were also made with the foster parents who appeared to show little direct concern over the youngster's welfare. His home visits were found not to be too satisfactory in that Jimmy often returned from them in a disturbed state.

After a year's time, however, sufficient change had taken place in him to signify he had benefited from the Center's permissive clinical atmosphere. The warm, accepting attitude of his cottage parent was a major factor in helping Jimmy transfer his hostilities from a destructive, sadistic medium to one in which he could express a good natured "rough house" relationship with both peers and adults. At school he was given the opportunity of special instruction both with his academic work and with a speech impairment. The latter, although not too noticeable, was considered a contributory factor in his aggressive makeup. He was further able to sublimate his aggressive drives through vigorous athletic activity, supervised by an accepting, yet firm recreational worker.

In the midst of Jimmy's last year at the Center the writer took over as the patient's caseworker. It was around this time especially that he complained most about wanting to leave the Center. The worker, through a good relationship, attempted to explore his feelings around discharge and evaluate his reasons for requesting it. He expressed many reasons. At first he complained the other children were too small for him, that he preferred his old school, then he criticized the rules as being too strict. It was after several hours of weekly discussion that he was finally able to verbalize that he had just had enough of the Center. He wanted a home to go to where people would "appreciate him" and where he could have lots of "ground to work and roam in" and "plenty of freedom." He wanted especially to earn money while doing this.

We discussed the possibilities of other placements at great length, stressing the reality potentials of each. At the same time the worker continued to evaluate his progress with the environment to ascertain his readiness to leave, if that seemed feasible. He furthermore began to see the foster parents frequently to clarify

any role they might play in the boy's future. Placement on a farm or any rural area of Jimmy's description seemed unfeasible and this was discussed with him. When other types of placements were mentioned, including the foster home he came from, he balked, complaining that in these places too much work would be expected of him. He even went to the extent of requesting admission to another institution as a way out of his predicament.

Jimmy revealed at this point more of his own ideas as to what constituted a foster home. It was here that he expected to find a Utopian family—one that would accept him for what he is, help him with his problems, give him the love and affection he needed, while at the same time expecting little from him in return. He was helped to understand this and to consider the entire idea of placement from a realistic point of view.

Eventually he requested more home visits with his foster parents and even spent Christmas vacation with them. At home he took on various household chores and volunteered to do some shopping. He picked up a part time job as a dish washer and was asked to return when he would be able to do so.

He came back from his home visits more and more elated, and his foster parents began to show increasing interest in him. Response to requests for clothing from them was immediate. They seemed more motivated to change because of the youngster's apparent efforts to do better. They began to develop some understanding of his behavior and of their own role in helping him to cope with his desire to be more independent. They moved to a larger home and better neighborhood, which helped improve the environmental atmosphere. Finally, the family's increasing requests to have Jimmy home, coupled with his own eagerness to return and his progress under treatment enabled the caseworker to discuss with the family plans for requesting custody. Petition to the Court for legal custody was made and granted. This was a big step in that it increased his feeling of security with his foster parents.

He was released on a three month trial visit, but not before considerable anxiety became evident on his part. He became more and more tense as the time for leaving drew near. Even after months of discussion, during which time he constantly pursued the worker for information about his discharge, he expressed amazement that the time had come so quickly. He asked if his friends would be leaving soon and wanted to know if he could return for a visit. When the caseworker drove him to the school in the community to talk with the principal, he asked the worker to drive around the block a few times, all the while wondering if he really made the right decision.

Throughout the last few months of his stay at the Center and during the trial visit period this case worker visited the school and discussed with the principal some of Jimmy's problems, such as his size in relation to grade placement, his slowness in grasping certain work, (particularly mathematics), his occasional tendency to bully younger children, and particularly his fears around returning to community living. Taking all the above factors into consideration, the principal, at Jimmy's request placed him in grade 8, although academically he was suited for grade seven. Here he would enjoy the status of joining his peers while at the same time knowing he must hold their respect by showing a serious attitude toward work. He was included in any decisions reached in these conferences. Occasional conferences between the worker and school staff during trial visit were planned and made.

This worker has since contacted the settlement house in the community and requested that they invite Jim to participate in some wholesome free time activity.

Discussion

Jim's adjustment during the trial visit period has been encouraging. His foster family continues to cooperate with us. At school he has been well liked, and is

described by his teacher (who taught him prior to his admission to the Center) as serious-minded and industrious. He has sought help in math from more advanced students and has maintained favorable classroom conduct. Promotion to the next higher grade is in the offing.

Although progress with this case has been encouraging many problems still remain to be solved. It should be noted that this youngster was confronted with the many anxieties about the move from a more protected environment back into the community, plus the bewilderment and ambivalent feelings of an adolescent seeking more freedom and independence. He will need further help from the caseworker and other understanding people with this conflict if he is to take up a satisfactory role in everyday society.

Planning for discharge is very difficult, but can be a very therapeutic process in itself. The attitude the child carries with him into the community might very well determine the effectiveness of his treatment as well as his ability to adjust to an uncertain and perhaps new environment. The child must have the opportunity to express his own ambivalence around leaving treatment, while at the same time receiving support in his efforts to plan ahead. He should, wherever possible, be introduced to contacts in the community so that the transition from institution to home becomes a more acceptable one.

The community—schools, physicians, recreational leaders, churches, social agencies, officers of the law, etc.—should be aware of the special problems which might face Jimmy and other youngsters who return to community living from the environs of the institution, in order to most effectively help them bridge this important step.

This Month In The Magazines

Collier's July 23, 1954—"Is the Secret of Cancer Locked in the Brain?" by Eric Northrup and John Gilmore.

Subtitle: "It May Be. A daring brain operation — still experimental — brings amazing relief to 'hopeless' cancer victims."

* * *

Summary: " . . . neurosurgeons, internists, and other specialists have teamed to uproot the pituitary gland—remove it in entirety from patients who have entered the 'terminal' or death stage of prostate, breast and other forms of cancer." "Uprooting man's hypophysis is now being tried by small groups of clinicians and researchers in at least five points on the globe—Stockholm, Paris, Havana, New York, Baltimore" . . . "Moreover, scientists hope that by removing the gland they may learn enough to find a drug or counterhormone that will eliminate the need for surgery and provide tomorrow's citizens with a major defense against cancer."

A.C.P. To Use TV Closed Circuit Telecast

On Thursday evening, September 23, 1954, from 6:00 p.m. to 7:00 p.m., Eastern Daylight Saving Time, the American College of Physicians will utilize television through a national closed circuit over the Columbia Broadcasting System to carry to its members and their colleagues a Symposium On The Management of Hypertension. This telecast is made possible through the co-operation and generous support of Wyeth Incorporated of Philadelphia, and will be the *first nationwide* closed circuit hookup for postgraduate medical education.

A "closed TV circuit" is one by which reception is controlled and not open to the general TV public. This telecast cannot be picked up in the home, but the invited audience must go to the TV receiving station. Twenty-three such receiving stations will be used; these will be located in Boston, New York, Philadelphia, Washington, Pittsburgh, Charlotte, Atlanta, Cincinnati, Detroit, Chicago, St. Louis, Milwaukee, Minneapolis, Memphis, Dallas, Houston, New Orleans, Denver, Salt Lake City, Los Angeles, San Francisco, Baltimore and Cleveland.

The Five Day Hospital Week

The *Bulletin of the Medical Society of the County of Kings*[1] comments on the five-day hospital week and asks "whether or not this is a blessing or a curse to the sick people"—

It seems as if but yesterday that hospitals functioned twenty-four hours a day and seven days a week. However, since the second World War, there have been serious changes in the management of hospitals and at amazing speed, so much so that the average doctor is at a loss when confronted with ever-changing innovations instituted in many hospitals. Among the changes now prevailing in the vast majority of hospitals, especially in the larger cities, is the establishment of the five-day hospital week. The pathologic and clinical laboratories, the x-ray department, the social service department, the administrative department, and many other departments function five days a week. Only a skeletal force of interns and residents is to be found in most hospitals on Saturdays and Sundays. It must be remembered that change and progress are not synonymous. It would be well for all of us to stop and to evaluate the consequences of the five-day hospital week. Many serious-minded doctors are beginning to complain that their patients are inadequately treated in the hospitals on week ends. Patients are complaining that they receive no treatment on week ends while in the hospital, and many of them protest that they are unjustly charged for these two days since nothing is being done for them at that time.

It is time to reflect whether or not the five-day hospital week is a blessing or a curse to the sick people. From every side we are being warned that doctors have a bad press, that there has developed a strained relationship between the lay people and the medical profession, that lay people are no longer regarding doctors as messengers of God, and that the public is turning to cultists and quacks because of the unfavorable propaganda against the medical profession. The fact of the matter is that the five-day hospital week is creating a good deal of the discord between the medical profession and the general public. It would be well for the leaders of medicine to stop and to think and to evaluate the end results of the five-day hospital week and to institute measures to remedy them. The treatment of the sick is the responsibility of the medical profession; it must not permit laymen to dictate how, where, and when to treat those who are ill.

We agree that the welfare of the sick person is, or should be, paramount. We think that all who operate the hospitals, administer them, and care for the sick do so with that consideration in mind. Since all are human beings with diverse backgrounds and training, it may well happen that the objective may not always be attained. It is true that

> . . . voluntary hospitals are regulated and controlled by lay people who comprise the board of trustees or directors of the hospitals, and who may "hire or fire" doctors at will. Nevertheless, it is the doctors who regulate the management of the average hospital, and directly are responsible for the reputation of any particular institution. Most lay people equate hospitals with doctors, and believe that it is the doctors who are responsible for the type of management of any given hospital. Consequently the type of treatment that lay people receive in hospitals will in a measure mould and determine the opinion of doctors held by laymen.

But only in a measure will this be so. The opinion lay people may have about doctors will in the final analysis be determined, will it not, by the doctors and their attitudes towards nonmedical people, sick or well?

The *Bulletin* presents an interesting argument if not, in our opinion, the whole story.

Editorial, *N.Y.S.J.M.*, July 1, 1954

[1] February, 1954, p. 58.

SKIN TEST DETERMINES TRUE SEX

A microscopic skin study which shows the true sex of an individual was recently described by a State University of Iowa scientist speaking before an annual meeting of the Endocrine Society in San Francisco.

Dr. Warren O. Nelson, professor of anatomy in the university's college of medicine, said research at SUI had confirmed a Canadian scientist's earlier report that a difference exists in the skin cells of males and females. This difference, Dr. Nelson said, can be used as a means of determining the true sex of an individual in whom faulty development prior to birth has resulted in both male and female characteristics.

The incidence of such cases, he added, probably is higher than many people believe. It is estimated that in one out of every thousand births, attending physicians are faced with some uncertainty as to the child's sex. A doctor can order the microscopic skin study in such a case and determine immediately whether the child should be reared as a boy or girl.

This does not eliminate the possibility of corrective surgery being needed in later years, Dr. Nelson emphasized, but the test at birth can eliminate the unhappiness that usually accompanies the discovery that a boy has been reared as a girl or vice versa.

First reported by Dr. Murray Barr of the University of Western Ontario in Canada, the difference lies in the nuclei of the skin cells. It is known that small masses of chromatin lie within the skin cell nuclei, and that in many of these nuclei there are such masses which cling to the inside wall. (Chromatin is a substance which scientists believe determines the physical characteristics that an individual inherits.)

Dr. Barr said he found that a high percentage of nuclei in a female's skin have these masses attached to the inside wall, but that such attached masses appear in few of the nuclei in male skin cells. His conclusion, therefore, was that a person's sex could be determined by the percentage of skin cell nuclei which include these attached masses of chromatin.

During the past year, Dr. Nelson and his associate, Dr. Eve Marberger, have conducted further studies, all of which have borne out Dr. Barr's report. In this research, skin from females showed that 69 per cent of the nuclei contained the masses attached to the edge, while skin from males showed such masses in only five per cent of the nuclei.

Dr. Nelson said the test has been used on several persons of indeterminate sex who have sought help at the University of Iowa hospitals. The test involves nothing more, he said, than taking from a person's body a small piece of skin, viewing it under the microscope and determining the percentage of cell nuclei in which small masses of chromatin are attached to the inside walls.

CONTENTS

MEDICAL SOCIETY OF DELAWARE
Peoples Church Community Hall
DOVER, DELAWARE
MONDAY, OCT. 11, 1954

8:30 p.m.—House of Delegates.

TUESDAY, OCT. 12, 1954

9:30 a.m.—Invocation: Rev. Robert W. Duke, Dover.

9:40 a.m.—Address of Welcome: Hon. W. Edward Haman, Dover.

9:50 a.m.—Report of House of Delegates: Norman L. Cannon, Wilmington.

10:00 a.m.—Description of Common Diseases of the Ocular Fundus, Robert J. Fox, Dover.

10:30 a.m.—The Chemotheraphy of Pulmonary Infections, William P. Boger, West Point, Pa.

11:00 a.m.—Exhibits.

11:30 a.m.—The Acute Abdomen, Victor P. Satinsky, Philadelphia.

12:30 a.m.—Luncheon: Members and Guests, Medical Society of Delaware.

2:00 p.m.—Importance of Early Diagnosis in Cancer of the Prostate, J. A. Campbell Colston, Baltimore.

2:40 p.m.—Functional Problems of Gynecology, Edmund R. Novak, Baltimore.

3:20 p.m.—Exhibits.

3:50 p.m.—Some Essentials in Office Proctology, Samuel McLanahan, Baltimore.

4:30 p.m.—Office Surgery for the General Practitioner, George P. Finney, Baltimore.

6:45 p.m.—Reception and Dinner (Subscription). Maple Dale C.C.

9:00 p.m.—Address: U. S. Senator, J. Allen Frear, Jr.

WEDNESDAY, OCT. 13, 1954

9:30 a.m.—American Medical Education Foundation: C. L. Hudiburg, Wilmington.

9:40 a.m.—The Preventable Complications of Myocardial Infarction, A. Henry Clagett, Jr., Wilmington.

10:20 a.m.—What Price Antimicrobial Therapy, Harrison F. Flippin, Philadelphia.

11:00 a.m.—Exhibits.

11:30 a.m.—Presidential Address: The Physician and Public Relations, Hewitt W. Smith, Harrington.

12:10 p.m.—Election of President-elect for 1955. (Sussex County).

12:30 p.m.—Luncheon: Members, Guests and Auxiliary. Kent County Medical Society.

Symposium on Traffic Accidents

2:00 p.m.—The Human Element in Accidents, Kenneth E. Appel and Albert E. Scheflen, Philadelphia.

2:40 p.m.—The Physician's Part In Highway Safety, Capt. C. Preston Poore, Dover.

3:20 p.m.—Exhibits

3:50 p.m.—Safety Education Program and the Physician. Mr. J. James Ashton, Wilmington.

WOMAN'S AUXILIARY, M. S. OF D.
TUESDAY, OCT. 12, 1954
Maple Dale Country Club

10:00 a.m.—Registration.

10:30 a.m.—Business Session; Guest Speaker: Mrs. George Turner, President, Woman's Auxiliary to A. M. A.

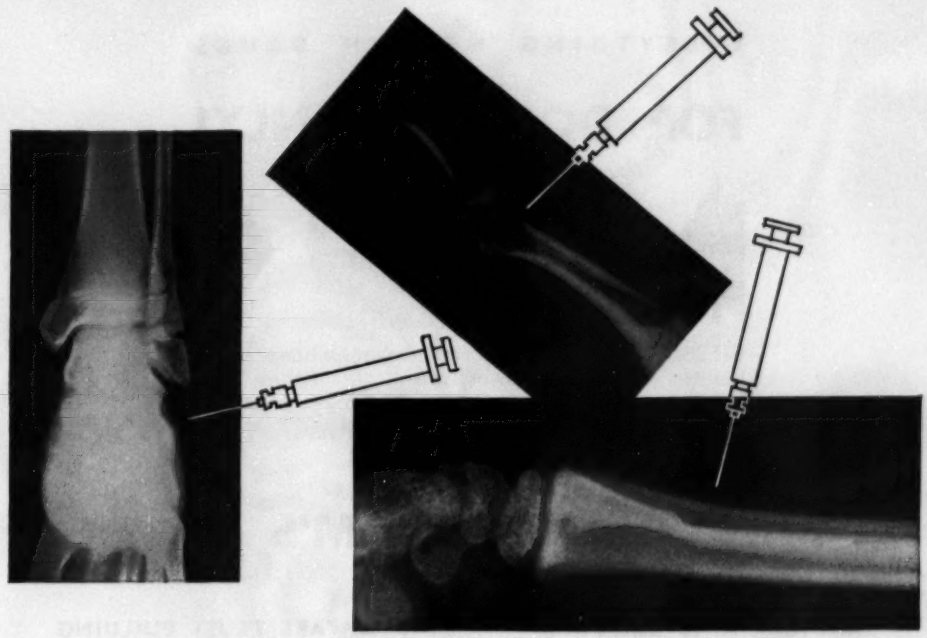
12:30 p.m.—Luncheon: Guest Speaker: Ernest B. Howard, Ass't. Secretary, A. M. A.

6:45 p.m.—Reception and Dinner (Subscription).

WEDNESDAY, OCT. 13, 1954
Peoples Church Community Hall

10:30 a.m.—Business Session and Election. Inaugural Address: Mrs. Gerald A. Beatty.

12:30 p.m.—Luncheon: Members, Guests and Auxiliary. Kent County Medical Society.



Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.

Swenson[2] has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises, "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.
2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

POST GRADUATE COURSE IN CARDIOLOGY HAHNEMANN MEDICAL COLLEGE & HOSPITAL

Starting in October, another postgraduate course in Cardiology will be given on Thursday afternoons from 2:00 to 5:00 for thirty sessions. Modern diagnosis and treatment of various forms of heart disease will be discussed. Registration is limited, and early enrollment is suggested.

Detailed information will be forwarded upon request to Lowell L. Lane, M.D., Department of Cardiology, Hahnemann Hospital, Philadelphia 2, Pennsylvania.

Approved by The American Academy of General Practice for formal credit.

hi!

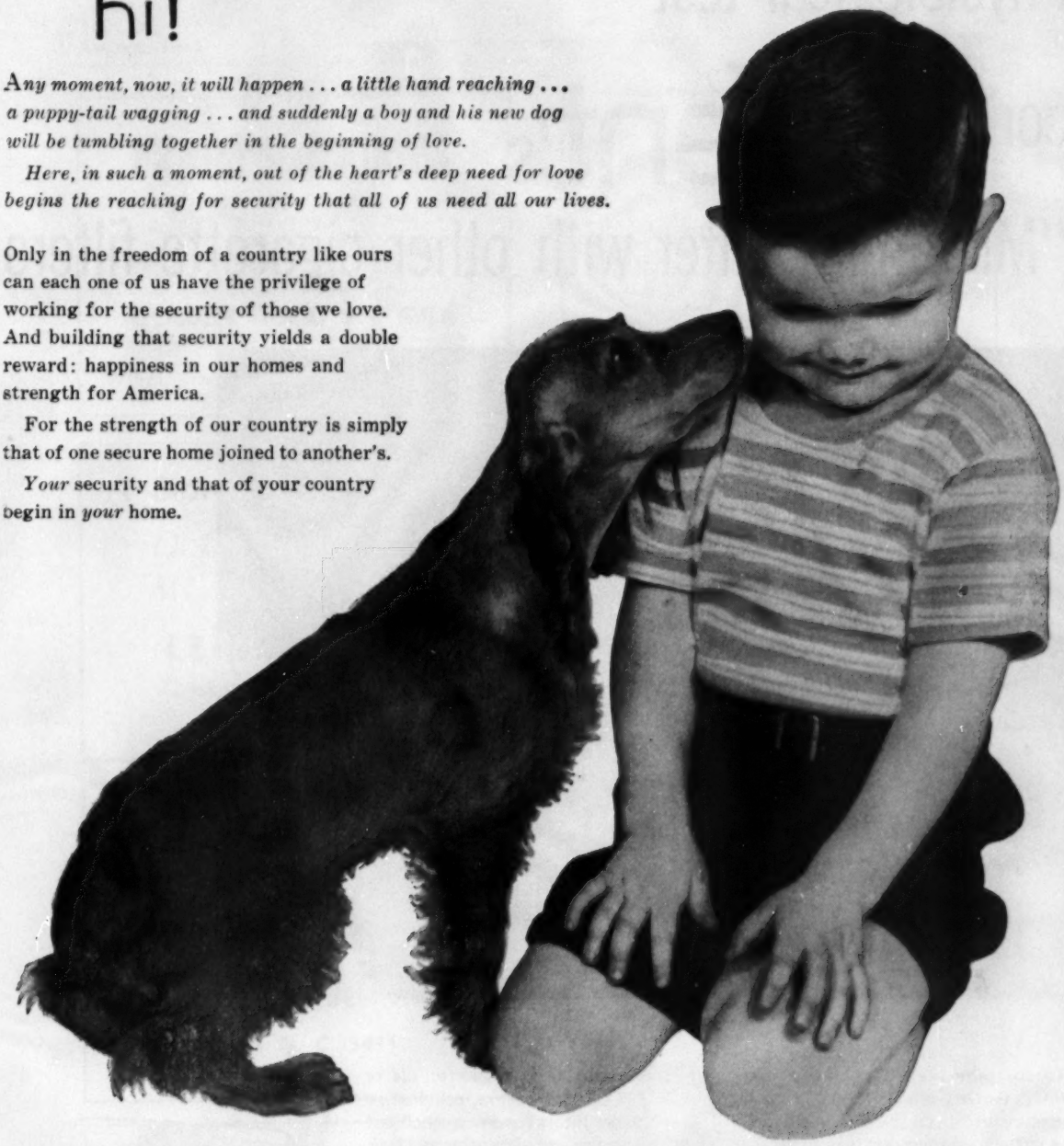
Any moment, now, it will happen . . . a little hand reaching . . . a puppy-tail wagging . . . and suddenly a boy and his new dog will be tumbling together in the beginning of love.

Here, in such a moment, out of the heart's deep need for love begins the reaching for security that all of us need all our lives.

Only in the freedom of a country like ours can each one of us have the privilege of working for the security of those we love. And building that security yields a double reward: happiness in our homes and strength for America.

For the strength of our country is simply that of one secure home joined to another's.

Your security and that of your country begin in *your* home.



Saving for security is easy! Read every word—now!

If you've tried to save and failed, chances are it was because you didn't have a *plan*. Well, here's a savings system that really works—the Payroll Savings Plan for investing in U.S. Savings Bonds. This is all you do. Go to your company's pay office, choose the amount you want to save—a couple of dollars a payday, or as much as you wish. That money will be set aside for you before you even draw your pay. And automatically invested in Series "E" U.S. Savings Bonds which are turned over to you.

If you can save only $3.75 a week on the Plan, in 9 years and 8 months you will have $2,137.30.

United States Series "E" Savings Bonds earn interest at an average of 3% per year, compounded semiannually, when held to maturity! And they can go on earning interest for as long as 19 years and 8 months if you wish, giving you a return of 80% on your original investment!

Eight million working men and women are building their security with the Payroll Savings Plan. For your sake, and your family's, too, how about signing up today? If you are self-employed, ask your banker about the Bond-A-Month Plan.

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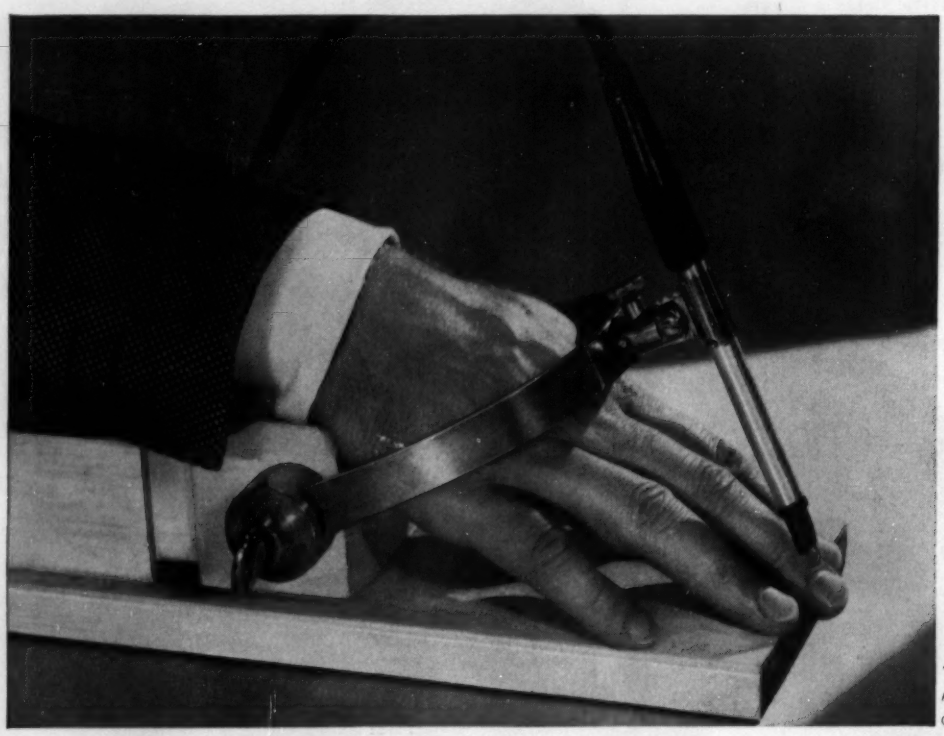
Physiological test compares Kent's "Micronite" Filter with other cigarette filters



"KENT" AND "MICRONITE" ARE REGISTERED TRADEMARKS OF P. LORILLARD COMPANY

To compare the efficiency of various filters as they affect physiological responses in the cigarette smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

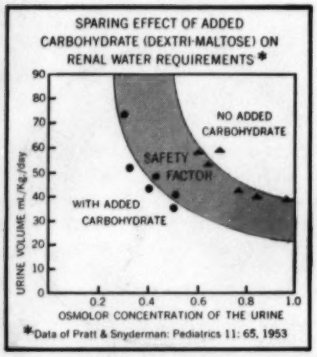
Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT with the exclusive Micronite Filter, may we suggest you do so soon?

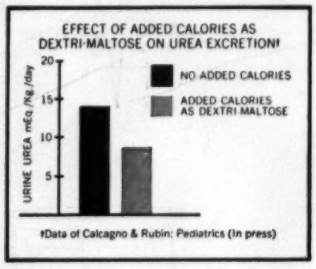
DEXTRI-MALTOSE *formulas*

provide important physiologic safeguards



Added renal safety. When the effective carbohydrate, Dextri-Maltose®, is added to cow's milk formulas, the infant's water requirements are reduced. This provides an added margin of safety against dehydration. In addition, the load on the water excretory capacity of the infant's immature kidneys is reduced.[1,2]

The margin of renal safety is especially important since various stresses and handicaps have been shown to influence the infant's fluid balance and renal capacity.[1,3,4,5]



Better nitrogen retention. The addition of adequate carbohydrate (Dextri-Maltose) to cow's milk formulas increases the infant's nitrogen retention and promotes the efficient use of nitrogen for growth,[2] causing a reduction in the excretion of urea and lightening the load on the infant's kidneys.

Ample carbohydrate is provided in a milk and water mixture by inclusion of 4 to 5% of Dextri-Maltose—or 1 tablespoonful to each 5 or 6 fluid ounces of formula.

With a record of forty-three years of outstanding clinical success, no other carbohydrate has earned such world-wide acceptance and confidence in its constant dependability as Dextri-Maltose.

1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagno & Rubin: Pediatrics (in press); 3. Calcagno, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Cooke, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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